Zulhasnimar bt Hassan Basri & Anor v Dr Kuppu Velumani P & Ors

HIGH COURT (KUALA LUMPUR) — CIVIL SUIT NO S4–22–1956 OF 2003
ROHANA YUSUF J
29 JULY 2011

Tort — Negligence — Medical negligence — Labour — Child born with cerebral palsy — Patient had to undergo hysterectomy — Whether mishaps caused by delay of medical practitioners who attended to patient — Whether there was delay in attending patient and diagnosing labour when patient came to hospital with abdominal pain — Whether elective caesarean section should have been planned — Whether patient was in labour upon admission or anytime — Probable cause of patient's collapse — Whether collapse foreseeable

The first plaintiff, the mother of the second plaintiff, claimed against the defendants based on the tort of medical negligence. Midway through the trial, the claim of the plaintiffs were only against the first, second and sixth defendants. The first defendant was a consultant obstetrics and gynaecologists who attended and performed the caesarean section ('CS') on the first plaintiff. The first defendant was assisted by the second defendant who was also a consultant obstetrics and gynaecologists. The sixth defendant was the owner of the hospital which the first and second defendants both have their practices at. It was alleged that the first defendant was negligent because she delayed in attending to the first plaintiff and failed to diagnose labour when the latter came to the hospital with abdominal pain. The first defendant was said to suppress labour in the first plaintiff by giving her Bricnayl and Pethedine. As a result of the delay and failure to diagnose labour, CS was also delayed. According to the plaintiffs, the first defendant missed three situations that called for the CS to be performed urgently on the first plaintiff. The plaintiffs averred that the first defendant should have contemplated that the first plaintiff, who was in labour, would be suffering from uterine rupture. The plaintiffs alleged that uterine rupture had caused the first plaintiff to bleed and her eventual collapse. Further, the first defendant was alleged to have delayed her attendance and management of the first plaintiff. Resulting from such alleged failures, the first defendant failed to make proper diagnosis of the first plaintiff and had performed the CS too late. This caused foetal distress which led to the cerebral palsy suffered by the second plaintiff. The plaintiffs also said there was no record of resuscitation or sufficient resuscitation, undertaken by the first defendant on the first plaintiff upon her collapse. The liability of the second defendant was predicated on him participating and assisting the first defendant in CS procedure. The plaintiffs contended that the duty of care of

the second defendant commenced upon him volunteering to assist the first defendant. The allegations against the hospital were that the hospital failed to provide proper and effective system to deal with the problem of the plaintiffs. The hospital was also said to have employed inefficient and incompetent staffs and failed to engage doctors, specialists, and consultants with sufficient skills to provide care and treatment to the plaintiffs. The issues that arose for the court's determination were: whether an elective CS should have been planned; whether the first plaintiff was in fact in labour upon admission or anytime; whether the first defendant provided the correct assessment in treating the first plaintiff: the probable cause of the collapse in the first plaintiff and whether the cause of collapse was foreseeable; whether the first defendant resuscitated the first plaintiff in the ward upon her collapse before sending her to the operation theatre ('OT'); whether the CS was properly undertaken by both the first and second defendants; and whether there was delay in the management of the first plaintiff.

Held, dismissing the appeal with costs:

(1) The plan for elective CS should be at 38 weeks gestation. The first defendant agreed that the first plaintiff needed CS but only at term. Since the event occurred in her 36 weeks of pregnancy, medical evidence seem to conclude that the event that had taken place in this case had occurred prior to any required planned CS. On this basis, there was no failure on the part of the first defendant in not preparing an elective CS at the point of the occurrence of this incident taking note that only at 38 gestations, a planned CS would have to be undertaken (see paras 39–40).

(2) The first plaintiff was not at any time in labour. The testimonies of the defendants' witness were well supported by the literature on the definition of 'labour'. Onset of labour was difficult to determine with accuracy and at most it could be said as, the time after which uterine contractions cause the progressive dilation of the cervix beyond 2cm with painful contractions usually occurring at least every 10 minutes. Both parties sometimes relied on the same literature and publications. However, the plaintiffs had not referred to them in their right context. There was nothing in all these publications that have placed reliance on contractions alone without dilation of cervix to indicate labour. All the literatures cited in fact, accepted the position that the contractions must be regular and progressive to establish that a patient is in labour, none of which was present in the first plaintiff at any given time (see paras 80–81).

(3) There were times when doctors' notes were written after the procedures were completed. These then became their recollections of the events that had taken place. Failure to note events and procedures in minute details could be excused. Variance in time was likely to occur in emergencies and

it was therefore not unreasonable for time recorded to be inexact. It would not be wrong for to surmise that all the doctors testifying in the trial were in chorus that entries by nurses and doctors were approximations, emergency records of time entries were made after the event. The more important consideration was to look at the effect and the management of the patient in itself (see paras 90–91).

(4) After the event, the first plaintiff collapsed at around 11am. A CS upon collapse was a delay. However since the first plaintiff did not present herself in a state of labour, there was no reason that an emergency CS would have to be performed anytime earlier. In view of that, a reasonable medical practitioner would not perform a CS in absence of labour. Thus the criticism that an earlier CS should have been done was clearly baseless (see para 105).

(5) The first defendant's did resuscitate the first plaintiff upon her collapse before sending her to the OT. The failure to record such procedure could not nullify this fact. The result on the patient clearly supported the case of the first defendant that she resuscitated the first plaintiff upon her collapse. Hence, there was no breach of duty or negligent on her part in the handling of the first plaintiff after the collapse (see para 118).

(6) It was clear that the abnormal representation of the first plaintiff's uterus of placenta percreta was not detectable upon routine antenatal check up. The detection of placenta percreta could usually happen only after delivery of baby when the placenta could not be delivered easily. The expert evidence of all witnesses also confirmed that it could not be detected even, through advanced imaging equipment. The placenta percreta itself did not cause pain, otherwise the first plaintiff would have suffered pain long before. From all accounts, it was obvious that the first defendant could not be expected to detect the placenta percreta in the uterus of the plaintiffs, or to foresee the events that happened. Thus, it was impossible to suggest that the first defendant should proceed with CS when there was a complaint of pain due to placenta percreta. There was no evidence to suggest that it was uterine rupture that caused the bleeding. Evidence was clear that the rupture of the uterine vein at the outer wall of the uterus led to massive bleeding (see paras 141–144).

(7) There was no evidence to support the suggestion that the first plaintiff collapsed at 10.30am. Based on the records, the first plaintiff collapsed approximately around 11am. Thus, taking into consideration of the fact that 'time' being an approximation, following the logical sequence of event, and the fact that the management of the first plaintiff was indeed in a state of emergency, and the time of collapse was approximately at 11am, the delivery of the second plaintiff within 30 minutes from the time of collapse was acceptable. In fact, it was an internationally accepted

standard. This fact could not therefore insinuate delay and poor management on the part of the first defendant given the circumstances (see para 150).

[Bahasa Malaysia summary

Plaintif pertama, ibu kepada plaintif kedua, mendakwa terhadap defendan berdasarkan tort kecuaian perubatan. Dalam pertengahan perbicaraan, tuntutan plaintif hanya terhadap defendan pertama, kedua dan keenam. Defendan pertama adalah seorang perunding obstetrik dan ginekologi yang telah merawat dan melaksanakan pembedahan caesarean ('CS') ke atas plaintif pertama. Defendan pertama telah dibantu oleh defendan kedua yang juga seorang perunding obstetrik dan ginekologi. Tertuduh keenam adalah pemilik hospital di mana defendan pertama dan kedua kedua-duanya beramal. Adalah didakwa defendan pertama telah cuai kerana lambat merawat plaintif pertama dan gagal untuk mendiagnosis plaintif sakit hendak beranak semasa dia datang ke hospital kerana sakit perut. Defendan pertama dikatakan telah memberikan Bricnayl dan Pethedine untuk mengurangkan sakit hendak beranak yang dirasai plaintif pertama. Hasil daripada kelewatan dan kegagalan untuk mendiagnosis sakit hendak beranak itu, CS juga ditangguhkan. Menurut plaintif, defendan pertama terlepas tiga situasi yang memerlukan CS dilakukan segera ke atas plaintif pertama. Plaintif menegaskan bahawa defendan pertama sepatutnya mempertimbangkan bahawa plaintif pertama, yang dalam kesakitan hendak beranak, akan mengalami pecah rahim. Plaintif mendakwa rahim yang pecah telah menyebabkan plaintif pertama mengalami pendarahan dan menyebabkan plaintif pengsan. Selanjutnya, defendan pertama telah dikatakan telah lewat memberi rawatan dan menguruskan plaintif pertama. Akibat daripada kegagalan yang dikatakan itu, defendan pertama gagal untuk membuat diagnosis yang betul ke atas plaintif pertama dan telah lambat melakukan CS. Ini menyebabkan tanda kesakitan janin yang membawa kepada palsi serebrum yang dialami oleh plaintif kedua. Plaintif juga menyatakan tidak ada rekod resusitasi atau bantuan pernafasan yang mencukupi, yang dilakukan oleh defendan pertama kepada plaintif pertama selepas dia tidak sedarkan diri. Liabiliti defendan kedua adalah berdasarkan penglibatan dan bantuannya kepada defendan pertama dalam prosedur CS. Plaintif-plaintif menegaskan bahawa kewajipan berjaga-jaga oleh defendan kedua bermula apabila dia sukarela untuk membantu defendan pertama. Tuduhan terhadap hospital adalah bahawa hospital telah gagal menyediakan sistem yang sesuai dan efektif untuk menangani masalah plaintif. Hospital ini juga dikatakan telah mengambil kakitangan untuk bekerja yang tidak cekap dan tidak kompeten dan gagal untuk melantik doktor, pakar dan perunding yang mempunyai kemahiran yang mencukupi untuk memberikan penjagaan dan rawatan kepada plaintif. Isu-isu yang timbul untuk ditentukan mahkamah ialah: sama ada pilihan untuk melakukan CS sepatutnya dirancang; sama ada plaintif pertama sebenarnya dalam kesakitan hendak beranak semasa masuk hospital atau bila-bila masa tersebut; sama ada defendan pertama telah

membuat penilaian yang betul dalam merawat plaintif pertama: sebab yang mungkin plaintif pertama tidak sedar diri dan sama ada punca keadaan tersebut boleh diramalkan; sama ada defendan pertama menyedarkan semula plaintif pertama di wad selepas dia tidak sedar diri sebelum membawanya ke bilik pembedahan ('BP'); sama ada CS telah dilakukan dengan betul oleh kedua-dua defendan pertama dan kedua; dan sama ada terdapat kelewatan dalam pengurusan plaintif pertama.

Diputuskan, menolak rayuan dengan kos:

(1) Rancangan unuk membuat pilihan CS patut apabila kandungan minggu ke-38. Defendan pertama bersetuju bahawa plaintif pertama memerlukan CS tetapi hanya apabila cukup bulan. Oleh kerana kejadian berlaku semasa kandungannya 36 minggu, keterangan perubatan membuat kesimpulan bahawa kejadian yang berlaku dalam kes ini telah berlaku sebelum apa-apa CS yang telah dirancang itu diperlukan. Beradasarkan ini, tiada kegagalan di pihak defendan pertama kerana tidak menyediakan pilihan CS semasa berlaku kejadian ini dengan mengambil kira kandungan yang hanya berusia 38 minggu, CS yang dirancang akan dilakukan (lihat perenggan 39–40).

(2) Plaintif tidak merasa hendak bersalin pada bila-bila masa. Keterangan saksi defendan-defendan disokong dengan definisi 'labour'. Permulaan sakit hendak beranak agak sukar untuk ditentukan dengan tepat dan paling boleh dikatakan sebagai, masa sebelum pengecutan rahim menyebabkan pengembangan progresif serviks melebihi 2cm dengan kontraksi yang menyakitkan biasanya berlaku sekurang-kurangnya setiap 10 minit. Kedua-dua pihak kadang-kadang bergantung kepada rujukan dan penerbitan yang sama. Walau bagaimanapun, pihak plaintif telah tidak dirujuk kepadanya dalam konteks yang betul. Tiada apa-apa dalam semua penerbitan ini yang telah meletakkan kebergantungan kepada pengecutan sahaja tanpa pengembangan serviks untuk menunjukkan tanda sakit hendak beranak. Kesemua rujukan yang dipetik sebenarnya, menerima kedudukan bahawa pengecutan mestilah kerap dan progresif untuk menandakan bahawa pesakit berada dalam kesakitan hendak beranak, yang mana bukan seperti dalam kes plaintif pertama pada mana-mana waktu tertentu (lihat prenggan 80–81).

(3) Ada ketikanya nota doktor telah ditulis selepas prosedur telah selesai. Ini kemudiannya menjadi ingatan semula mereka tentang peristiwa-peristiwa yang telah berlaku. Kegagalan untuk mengambil perhatian terhadap kejadian dan prosedur secara terperinci boleh dimaafkan. Perbezaan masa itu mungkin berlaku dalam keadaan kecemasan dan oleh itu bukan suatu yang tidak munasabah di mana masa yang dicatatkan adalah tidak tepat. Ia tidak salah untuk mengandaikan bahawa semua doktor memberi keterangan dalam perbicaraan itu

bersependapat bahawa catatan oleh jururawat dan doktor adalah anggaran, rekod kecemasan tentang masa nota-nota tersebut dibuat selepas kejadian itu. Pertimbangan yang lebih penting adalah untuk melihat kesan dan pengurusan pesakit itu sendiri (lihat perenggan 90–91).

(4) Selepas peristiwa itu, plaintif pertama tidak sedar diri kira-kira jam 11 pagi. Satu CS selepas keadaan tidak sedar diri adalah suatu yang terlewat. Namun kerana plaintif pertama tidak menunjukkan dirinya dalam keadaan sakit hendak beranak, tidak ada sebab perlu dilakukan CS kecemasan pada bila-bila masa lebih awal. Sehubungan itu, pengamal perubatan yang munasabah tidak akan melakukan CS jika tiada keadaan sakit hendak beranak. Oleh itu kritikan bahawa CS yang lebih awal sepatutnya dilakukan jelas tidak berasas (lihat perenggan 105).

(5) Defendan pertama telah memulihkan semula plaintif pertama selepas dia tidak sedarkan diri sebelum menghantarnya ke BP. Kegagalan untuk mencatat prosedur tersebut itu tidak boleh menidakan fakta ini. Keputusan pada pesakit dengan jelas menyokong kes defendan pertama bahawa dia telah memulihkan semula plaintif pertama selepas dia tidak sedarkan diri. Oleh itu, tidak terdapat sebarang pelanggaran kewajipan atau kecuaian di pihaknya dalam mengendalikan plaintif pertama selepas dia tidak sedarkan diri (lihat perenggan 118).

(6) Ia adalah jelas bahawa representasi tidak normal rahim plasenta percreta plaintif pertama tidak dikesan apabila rutin pemeriksaan antenatal dilakukan. Pengesanan plasenta percreta biasanya boleh berlaku hanya selepas kelahiran bayi apabila plasenta tidak dapat dikeluarkan dengan mudah. Keterangan pakar semua saksi juga mengesahkan yang ia tidak dapat dikesan walaupun, melalui peralatan pengimejan yang canggih. Plasenta percreta itu sendiri tidak menyebabkan kesakitan, jika tidak, plaintif pertama akan mengalami sakit lama sebelum ini. Berdasarkan kesemua fakta, ia adalah jelas bahawa defendan pertama tidak boleh dijangka untuk mengesan percreta plasenta dalam rahim plaintif, atau meramalkan peristiwa-peristiwa yang berlaku. Oleh itu, ia adalah mustahil untuk mencadangkan bahawa defendan pertama perlu meneruskan dengan CS apabila terdapat aduan sakit akibat plasenta percreta. Tidak ada bukti yang menunjukkan bahawa rahim yang pecah itu telah menyebabkan pendarahan. Keterangan adalah jelas bahawa urat rahim yang pecah pada dinding luar rahim membawa kepada pendarahan yang banyak (lihat perenggan 141–144).

(7) Tidak ada bukti untuk menyokong cadangan bahawa plaintif pertama tidak sedarkan diri pada 10.30 pagi. Berdasarkan rekod, plaintif pertama tidak sedarkan diri lebih kurang jam 11 pagi. Oleh itu, dengan mengambil kira fakta bahawa 'masa' sebagai anggaran sahaja, berikut turutan logik kejadian, dan fakta bahawa pengurusan plaintif pertama

A sememangnya dalam keadaan kecemasan, dan masa keadaan tidak sedarkan diri itu adalah kira-kira pada jam 11 pagi, kelahiran plaintif kedua dalam tempoh 30 minit dari masa keadaan tidak sedarkan diri itu boleh diterima. Malah, iaitu standard yang diterima di peringkat antarabangsa. Oleh itu fakta ini tidak boleh mencadangkan kelewatan B dan pengurusan yang lemah di pihak defendan pertama berdasarkan hal keadaan itu (lihat perenggan 150).]

Notes

For cases on medical negligence, see 12(1) *Mallal's Digest* (4th Ed, 2013 C Reissue) paras 1416–1423.

Cases referred to

Bolam v Friern Hospital Management Committee [1957] 2 All ER 118, QBD (refd)

D *Bolitho (administratrix of the estate of Bolitho (deceased) v City and Hackney Health Authority* [1997] All ER 771, HL (refd)

Chien Tham Kong v Excellent Strategy Sdn Bhd & Ors [2009] 7 MLJ 261; [2008] 1 LNS 411, HC (refd)

E *Chin Keow v Government of Malaysia & Anor* [1967] 2 MLJ 45, PC (refd)

Elizabeth Choo v Government of Malaysia & Anor [1970] 2 MLJ 171 (refd)

Foo Fio Na v Dr Fook Mun & Anor [2007] 1 MLJ 593; [2007] CLJ 229, FC (refd)

Hor Sai Kong dan satu lagi v Universiti Hospital dan satu lagi [2002] 5 MLJ 167, F HC (refd)

Huck v Cole [1993] Med LR 393 (refd)

Krisnan Nambiar Prabakaran & ors [2009] 4 MLJ 267; [2008] 10 CLJ 215, HC (folld)

Maynard v West Midlands Regional Health Authority [1985] All ER 635, HL G (refd)

PP v Dr Nadason Kanagaligam [1985] 2 MLJ 122 (refd)

Rogers v Whitaker (1992) 17 CLR 479, HC (refd)

Sidaway v Board of Governors of the Bethelm Royal Hospital and Maudsley Hospital and Others [1985] 1 AC 871, HL (refd)

H *Swamy v Mathews & Anor* [1967] 1 MLJ 142 (refd)

Legislation referred to

Evidence Act 1950 s 45

I Rules of the High Court 1980 O 34

PS Ranjan (Manmohan S Dhillon with him) (PS Ranjan & Co) for the plaintiff.
Darryl ST Goon (Maidzuara Mohammed with him) (Raja Darryl & Loh) for the first, second and fifth defendants.
S Anpalagar (Anad & Noraini) for the sixth defendant.

Rohana Yusuf J:

[1] This is a tragic case involving a young 34 year old mother who was pregnant with her second child. She had gone to Ampang Puteri Specialist Hospital complaining of abdominal pain and had collapsed as a result of severe bleeding that had ensued. The loss of consciousness had, in the most unfortunate circumstances, caused the baby to suffer from cerebral palsy resulting in severe birth asphyxia. The length of the proceedings, which stretched went well over 50 days and involved the testimony of 12 medical doctors and four others, underline the complicity and intricacy of the case.

BACKGROUND FACTS

[2] The first plaintiff, Zulhasnimar binti Hassan Basri was expecting her second child. She had earlier given birth to her first born at the Ampang Puteri Specialist Hospital by Lower Segment Caesarean Section ('LSCS'), on 25 April 2000 following a failed trial of labour. She was having *camphol-pelvic disproportion* (CPD); a condition that occurs when a baby's head or body is too large to fit through the mother's pelvis. She was in good condition when she was then discharged with the first baby two days later, on 27 April 2000.

[3] She went back to the hospital for her second pregnancy and saw the same doctor who is the first defendant, for her antenatal checkups. She underwent a total of four antenatal checkups. No abnormality was detected in her condition or the foetus. Her antenatal records are found in Bundle B pp 246–247 (transcribed in Bundle F pp 10–11). Her last antenatal check-up was at 32 weeks gestation on 12 April 2002. Her antenatal report showed that her condition was normal. An ultra sound of the foetus showed that the baby was healthy, which certainly did not give rise to any concern. The expected date of delivery (EDD) was on 31 May 2002.

[4] In the early morning of 3 May 2002, she went to the hospital complaining of abdominal pain. She was in her 36 weeks gestation. She was attended to by a staff nurse and after having performed various checks on her, she was admitted into the hospital. On the instruction of the first defendant she was given medication by the nurse. Later that morning the first defendant visited her in the ward.

[5] Sometime between 10.50am to 11am that morning, the first plaintiff collapsed as a result of severe bleeding. Her blood pressure was not recordable. A code blue alarm for emergency was sounded. The first defendant said she resuscitated the first plaintiff and thereafter transferred her to the operation theatre (OT). Encik Sariman bin Saad (PW2) the husband of the first plaintiff,

said he heard the code blue alarm when he came to see his wife. According to him, the first defendant told him that an emergency operation was required, and he was asked to sign documents in B284 and in B285 to consent to a caesarean section (CS) and a hysterectomy of his wife.

[6] An emergency CS and a subtotal hysterectomy were performed by the first defendant. The first defendant was assisted by Dr Marlik Abu, who like the first defendant, is also a consultant obstetrician and gynaecologist at the hospital. He came to the assistance of the first defendant in respond to the code blue alarm. He is the second defendant in the present suit.

[7] The cause of bleeding that eventually resulted in the first plaintiff's loss of consciousness was heavily disputed. The plaintiffs averred that, the severe bleeding was caused by the rupture of the first plaintiff's uterine and the defendants had neglected to prevent it. This is because according to the plaintiff's case a *uterine rupture* is a foreseeable condition of the first plaintiff who as a result of the earlier delivery by CS had a CS scar. The defendants' version was that the severe bleeding was due to rupture of the blood vessels on her uterus. This condition was brought about because the first plaintiff had an abnormal presentation of her uterus. There are three abnormal presentations of the uterus. They are placenta accreta, placenta increta and placenta pecreta.

[8] No matter what the cause of the severe bleeding may be, there is no doubt that it had caused the first plaintiff to lose consciousness and the second plaintiff to be born prematurely with severe prenatal asphyxia and with transient multi-organ failure.

[9] The first plaintiff narrated the episode after her delivery. She said she only saw her baby on the second day of delivery. The first defendant then told her that she had to undergo an emergency CS. She said the first defendant explained to her that her internal organ had burst and she had to be operated on to save her life. She was told that her uterus was surgically removed during the emergency CS. She was discharged from the hospital after three days. She further testified that Dr Haliza bt Mohamad Shafie (the consultant paediatric and the fifth defendant) told her that her baby's condition was bad but did not tell her the cause. Her baby, Khairina Puteri bt Sariman (the second plaintiff) was taken to a public hospital, the Selayang Hospital after 21 days. This was because she could not afford the bills at Ampang Puteri Hospital. At the time she testified in court, Khairina according to her would be four years and she is different from her first child. Khairina is not able to talk or do anything for herself. Khairina has been in and out of the hospital ever since and she was told that Khairina suffered from brain damage. Khairina is in fact suffering from a severe form of cerebral palsy.

THE CONDITION OF THE SECOND PLAINTIFF

[10] There is no dispute as to the condition of the second plaintiff. She is suffering from severe birth asphyxia leading to hypoxic ischemic encephalopathy (HIE). In a text by Forfar and Arneil's textbook (exh P25) referred to by learned counsel for the plaintiffs, learned author says that *'Birth asphyxia is the most common and important cause of preventable cerebral injury in the neo natal period'*. An expert witness on neonatologist Professor Dr Lim Chin Thean (CT Lim) who testified as PW2 agreed with this statement. It is also the testimony of PW2 that in treating and handling such a case, every minute counts as it would make a difference to the condition of the baby. He further opined that a baby born in a mother at 36 weeks gestation who collapsed with a CS undertaken has a high chance to be born with neurological abnormalities. The fifth defendant a consultant paediatrician, the late Dr Haliza bt Mohd Shafie testified that there was a fatal distress before the birth of the second plaintiff and this could have resulted in the condition of the second plaintiff.

[11] The plaintiffs attributed the condition befallen on the second plaintiff on the defendants' failure to deal with first plaintiff's condition spontaneously. Relying on the decision in the case of *Hor Sai Kong & satu lagi v Universiti Hospital & satu Lagi* [2002] 5 MLJ 167 learned counsel for the plaintiffs, Mr PS Ranjan (Mr Manmohan Singh with him), submitted that the baby in that case was found to have suffered from the same condition as the second plaintiff because the CS was undertaken too late on the mother. Professor Dr CT Lim who was a witness in the above case testified that a culpable delay of merely 15 minutes involving fatal distress had caused, or materially contributed to the brain damage suffered by the baby in the above case. It was suggested by the plaintiffs that the circumstances in the present case were similar in that there had been culpable delay.

[12] Relying on this authority and the opinion of Professor Dr CT Lim the plaintiffs' mounted their case against the defendants that the alleged delay by the first defendant to perform CS on the first plaintiff has contributed to the condition suffered by the second plaintiff.

THE PARTIES

[13] The parties to this action are the following The first plaintiff, Zulhasnimar bt Hasan Basri is the natural mother of the second plaintiff. The second plaintiff Khairina Puteri bt Sariman is suing through her father and next of friend Sariman bin Saad.

[14] The first defendant, Dr Kuppu Velumani is a consultant obstetrics and gynaecologists with over 22 years of experience. She was the doctor in

attendance to the first plaintiff and who performed the CS. The second defendant Dr Marlik Abu is also a consultant obstetrics and gynaecologists with over 15 years of experience. He assisted the first defendant in the CS. They both have their practices at the Ampang Puteri Specialist Hospital, at No 1 Jalan Mamanda 9, Taman Dato' Ahmad Razali, 68000 Ampang Selangor. The hospital is owned by the sixth defendant.

[15] The third defendant, Dr Ami Balasingam and the fourth defendant Dr Azhar Mohamed Noh are consultant anaesthesiologists. They both were having their practices at the same hospital at the material time. They were the anaesthetists attending to the first plaintiff in the OT. The plaintiffs eventually discontinued their claims against both the third and fourth defendants.

[16] The fifth defendant Dr Haliza Mohamad Shafie was a consultant paediatrician. She passed away during the course of the trial after having given her testimonies (may Allah bless her soul). Upon her demise, no claim was pursued against her estate. Hence, there is no longer a claim against the fifth defendant or her estate.

[17] Midway through the trial, the claim of the plaintiffs were only against the first, second and sixth defendants.

[18] There were six medical expert witnesses testifying in the course of the trial. The two consultant obstetrics and gynaecologist testifying as expert witnesses were Dr Ong Hee Choon and Dr Raman s/o Subramaniam. Dr Ong Hee Choon is a consultant obstetrics and gynaecologists with 34 years experience. He testified as PW3 for the plaintiffs. Dr Raman s/o Subramaniam is a consultant obstetrics and gynaecologist with 29 years of experience. He testified as DW7 for the defendants. These two expert witnesses are highly qualified with varied experiences in their area of specialisation both in practice and academia. They have written extensively on the subject.

[19] The other two expert witnesses were consultant paediatricians. consultant paediatrician, Dr Shanmuganathan a/l N Narayanan, had over ten years experience and specialising in paediatric and community paediatrician. He testified as an expert witness for the plaintiffs as PW4. The consultant paediatric who testified for defendants was Dr Hussain Imam bin Muhammad Ismail. He had over 20 years experience as consultant paediatric, with varied experience both academically as well as paediatric practice.

[20] Professor Dr Lim Chin Theam is an expert witness for the defendant who testified as DW2. He is a consultant paediatrician experienced in the area of neonatology.

[21] Dr Sylvian Dass is a consultant anaesthesiology intensive care and pain management. He is now practising at Pantai Medical Centre, Bangsar, Kuala Lumpur. He is a doctor with 20 years experience. He testified as PW7.

[22] The other medical witnesses are both the first and second defendants, Dr Kuppu Velumani and Dr Marlik bin Abu, Dr Haliza binti Mohd Shafie the fifth defendant, Dr Navinbhai Patel a consultant pathologist who did the prognosis of the uterus of the first plaintiff after the operation. Other doctors who testified in the trial includes Dr Wan Jazilah bt Wan Ismail and Dr Ranjini a/p Sivaneson.

THE CLAIM OF THE PLAINTIFFS

[23] The plaintiffs' claim is based on medical negligence. The first plaintiff is suing the defendants together with the second plaintiff, through her father and next friend, Sariman bin Saad. The plaintiffs alleged negligence on the part of the first defendant, which are particularised in the statement of claim as follows:

(i) failed to consider sufficiently or at all the first plaintiff's obstetric history;

(ii) failed to undertake or order sufficient examination and investigations and monitoring of the condition of the plaintiffs and each of them;

(iii) failed to consider sufficiently or at all the symptoms and signs of uterine rupture, placenta accrete or excreta and fatal distress;

(iv) failed to act sufficiently or at all and within time upon the steady and obvious deterioration of the condition of the first plaintiff and Second plaintiff;

(v) failed to provide necessary care and treatment within time or at all;

(vi) gave Briancanly orally to the first plaintiff at 36 weeks gestation so as to suppress labour;

(vii) delegated inappropriately or excessively to the nursing staff her duty to examine, observe and treat the plaintiffs;

(viii) failed to undertake at all and without delay an elective Caesarean section;

(ix) failed to undertake early enough the emergency laparotomy and the emergency LSCS;

(x) failed to undertake adequate assessment of the first plaintiff's condition and to treat her adequately in the ward or labour and delivery room before she was transferred to the operation theatre;

(xi) failed to make findings of placenta excreta and uterine rupture early enough; and found placenta excreta and uterine rupture only after failed controlled cord traction;

(xii) undertook controlled cord traction when she knew or ought to have known that there was placenta excreta and that it was dangerous to undertake the procedure;

(xiii) failed to remove the placenta safely from uterus;

(xiv) delayed in removing the placenta along with the uterus;

(xv) failed consider or act upon sufficiently or early enough the symptoms and signs internal bleeding;

(xvi) aggravated the fatal distress;

(xvii) failed to undertake sufficient resuscitative measures; and

(xviii) allowed a uterine rupture to occur.

Particulars of Negligence of the second defendant and

(xix) The plaintiffs repeat as against the second defendant the particulars alleged as against the first defendant, save for those contained in sub-paras vi, vii and viii.

[24] In summary the plaintiffs' case against the defendants are these. The first plaintiff at 36 weeks gestation came to the hospital on 3 May 2002 with abdominal pain. She was in labour and was in urgent need of a CS because of her past medical history of CPD. The first defendant is said to be negligent because she delayed in attending to the first plaintiff and failed to diagnose labour. She was said to suppress labour in the first plaintiff when she gave bricnayl and pethedine. Her alleged delay and failure to diagnose labour had caused delay in the performing of CS. According to the plaintiffs she had missed three situations that called for the CS to be performed urgently on the first plaintiff.

[25] The first defendant, according to the plaintiffs should have contemplated that the first plaintiff, who was in labour, would be suffering from *uterine rupture*. *Uterine rupture* is a condition associated with her first pregnancy. The plaintiffs alleged that *uterine rupture* had caused the first plaintiff to bleed and her eventual collapse. Due to the failure of the first defendant to contemplate or foresee that the first plaintiff would suffer from *uterine rupture*, the first defendant is said to be negligent in allowing the first plaintiff to collapse. The collapse of the first plaintiff had caused fatal distress to the second plaintiff.

[26] Further, the first defendant is alleged to have delayed her attendance and management of the first plaintiff. Resulting from such alleged failures the first defendant failed to make proper diagnosis of the first plaintiff and had performed the CS too late. This has caused foetal distress which led to the condition suffered by the second plaintiff.

[27] The plaintiffs also said there was no record of resuscitation or sufficient resuscitation, undertaken by the first defendant on the first plaintiff upon her collapse. Only the OT notes states *initial resuscitation* was done in the OT. Relying on this note and the lack of other recordings, the plaintiffs contended that the first defendant did not resuscitate the first plaintiff in the maternity ward upon her collapse. The delay to resuscitate the first plaintiff worsened and distressed the foetus further. Premised on these alleged failures and negligence it is the plaintiffs' case that the first defendant, is negligent and liable to the damage suffered by both plaintiffs.

[28] The liability of the second defendant is predicated on him participating and assisting the first defendant in CS procedure. The plaintiffs contended that the duty of care of the second defendant commenced upon him volunteering to assist the first defendant. For this reason he should also be held liable to the damage.

[29] The allegations against the hospital are that the hospital failed to provide proper and effective system to deal with the problem of the plaintiffs. The hospital is also said to have employed inefficient and incompetent staffs and failed to engage doctors, specialists, and consultants with sufficient skill to provide care and treatment to the plaintiffs.

THE CASE OF THE FIRST DEFENDANT

[30] In her defence, the first defendant's case is as follows. The first plaintiff was admitted at about 6.30am, with lower abdominal pain. Upon reports by the staff nurse in attendance, she concluded that the first plaintiff was not in labour and prescribed her with pethidine and phenergan to suppress the pain of abdominal muscles. She finds such condition common in a pregnant lady at 36 weeks gestation. After treating her with some medication, she ordered for the first plaintiff to be put in the maternity ward. The first plaintiff collapsed due to severe bleeding. The bleeding is caused by an abnormal presentation of her placenta called *placenta pecreta*. She did not have *uterine rupture* but her vessel at the fundus ruptured causing massive bleeding at the placental site. This is associated with the *placenta percreta*. The condition *placenta percreta* cannot be detected earlier even by the most advanced of equipments. It was only discovered upon delivery of the baby, when the placenta cannot be removed as easily.

[31] The first defendant maintained that there was no indication that warranted a CS to be performed on the first plaintiff until she collapsed. Upon the collapse of the first plaintiff, the first defendant called code blue. She resuscitated the first plaintiff though she admitted not recording the same in her notes. After resuscitating, she sent her to the OT. She proceeded to perform

CS on her at the OT assisted by the second defendant who responded to code blue. She took about 30 minutes to deliver the baby from the time the mother collapsed. The time taken according to her is reasonable, if not exemplary.

[32] After delivering the baby, the first defendant said she passed the baby to the waiting consultant paediatric, the late Dr Haliza (the fifth defendant). Meanwhile, the first defendant removed the placenta and sent it for biopsy. The prognosis was that the first plaintiff suffered from a condition called *placenta percreta.*

[33] The second defendant's case is that he was assisting the first plaintiff in response to the call for code blue. He was not involved in any other part of the case. He had successfully assisted the first defendant to do hysterectomy.

THE ALLEGATIONS OF NEGLIGENCE

[34] Broadly speaking, the plaintiffs bear the burden of proving negligence on balance of probabilities as decided in a number of cases on medical negligence in this country. Harking back to this principle, to succeed on the claim against the defendants it is incumbent upon the plaintiffs to prove firstly that, Dr Kuppu Velumani P and Dr Marlik Abu owe the plaintiffs a duty of care, that both Dr Kuppu Velumani P and Dr Marlik Abu have breached that duty. The hospital has breached its duty of care in failing to provide the required services to the plaintiffs. Resulting from that breach the plaintiffs suffered damages which are not too remote. In the case of the sixth defendant, the vicarious liability would arise if the claim against the first and second defendants succeeds.

[35] There are major disputes that need to be resolved in determining the claim of the plaintiffs. In summary the main issues before the court are these:

(a) whether an elective CS should have been planned;

(b) whether the first plaintiff was in fact in labour upon admission or anytime; and that the first defendant had in fact provided the correct assessment in treating the first plaintiff:

(c) what is the probable cause of the collapse in the first plaintiff; Is it due to *uterine rupture* or rupture of the vessels on the uterus resulting from a condition called *placenta percreta*;

(d) whether the cause of collapse is foreseeable by the first defendant;

(e) whether The first defendant resuscitated the first plaintiff in the ward upon her collapse before sending her to the OT;

(f) whether the CS was properly undertaken by both the first and second defendant;
and

(g) whether there was delay in the management of the first plaintiff by the first defendant.

ELECTIVE CS NOT PLANNED

[36] First, the first plaintiff's allegation is that the first defendant (Dr Kuppu Velumani) failed to advise the first plaintiff or to prepare her for an elective CS in view of her first pregnancy medical history. Her medical history is available in the records of the Ampang Putri Hospital. It is an undisputed fact that from her medical records the first plaintiff has a history of CPD in her first pregnancy. The view of the expert witness Dr Ong Hean Choon (Dr Ong) is that a person who has CPD should be prepared for an elective CS in her second pregnancy. In his written opinion tendered in court marked as exh Pl-B he opined in para B at p 65 that:

> *B Her previous pregnancy*
>
> This patient had an emergency caesarean section (CS) done on 25–04–00 at 38 weeks, for failed trial of labour and cephalo-pelvic disproportion (CPD). A live female baby, weighing 2.8kg was delivered.
>
> *Comment*
>
> In view of the indications for CS in year 2000, ie failed trial of labour and cephalo-pelvic disproportion, this means that subsequent pregnancies in this patient should be delivered by elective CS, as it would not be safe for her to undertake a vaginal delivery.

[37] In cross-examination Dr Ong states that the diagnosis of CPD recorded in the year 2000 during her first pregnancy shows that the first plaintiff had failed trial of labour and she had a CS done on her. By that reason Dr Ong opines she should be planned for a CS in her second pregnancy. With the presence of the scar of the last CS he said there are all the more reasons to plan her for a CS and that would have been a safer approach to be taken. Though there is no hard and fast rule, a safer approach ought to be taken. Nevertheless, if a CS is to be planned Dr Ong said it should take place at 38 weeks gestation.

[38] Various publications were produced to suggest to Dr Ong by learned counsel for the first defendant, Mr Daryl SC Goon (Maidzura bt Mohammad with him) that, a patient with history of earlier CS should be given a chance for a vaginal birth after caesarean (VBAC). This view is found in the SOGC

Clinical Practice Guidelines exhibited as D6. In exh D7, Green Top Guidelines No 45 RCOG titled *Birth After Previous Caesarean Birth* it is suggested that a woman should be informed of VBAC's success rate of 40%. In response to these suggestions Dr Ong commented that, in relation to the first plaintiff, VBAC should not be considered but an elective CS should be recommended. He said, even though, the baby appears to be smaller in weight than the first pregnancy unless appropriate medical risk and benefit is discussed, VBAC is not an option based on weight per se. In the same light, in discussing the literature suggested by learned counsel for the defendants in exh D9 his response was it should not be based on head circumference per se, as suggested in exh D10. Exhibit 9 is a textbook, *Donald School Textbook of Ultrasound*, on the topic discussed *Fetal Growth and Biometry*. Exhibit D10 is a book on *Obstetrics Illustrated on Normal Newborn Baby* this topic is found in p 356.

[39] In the final analysis I do not find it necessary to delve further into this area except to accept the evidence of Dr Ong that a patient like the first plaintiff found to be with CPD should be planed for an elective CS. In this regard I note that according to Dr Ong, the plan for elective CS should be at 38 weeks gestation. Dr Kuppu Velumani in her evidence agreed that the first plaintiff needed CS but only at term. In cross-examination she reiterated her agreement that the first plaintiff who had CPD should have CS after completing 38 weeks gestation.

[40] Since the event occurred in her 36 weeks of pregnancy, medical evidence seem to conclude that the event that had taken place in this case has occurred prior to any required planned CS. On this basis, there is no failure on the part of Dr Kuppu Velumani in not preparing an elective CS at the point of the occurrence of this incident taking note that only at 38 gestations, a planned CS would have to be undertaken.

PLANNED CS AS OPPOSED TO EMERGENCY CS

[41] There is no doubt that as event unfold in this case, the first plaintiff went through as emergency CS. Learned counsel for the plaintiffs Encik PS Ranjan (Encik Manmohan Singh with him) suggested that even if the first plaintiff was not in labour, an elective CS as opposed to emergency CS would be a proper administration of the first plaintiff. He contended, following Dr Ong's expert view that, a planned CS should have been performed and would be a safer option in the circumstances of this case. Dr Ong's opinion is that there were a couple of situations that arose in the present case which called for the CS to be performed on the first plaintiff.

[42] Dr Kuppu Velumani on the other hand testified that to do a CS at preterm would pose a risk to the foetus. The expert witness Dr Raman agreed

that if there is indication of onset of labour it would be reasonable to do a CS at 36 weeks, but there is no indication shown in this case for the first defendant to take such step. Encik PS Ranjan submitted that the first defendant should have proceeded with CS even if there is no labour in view of the first plaintiff's history of CPD. Taking into account her pass history he said, she would be at risk of *uterine rupture*, as later on presented in this case.

[43] In response to this proposition, Dr Kuppu Velumani maintained that a CS at preterm and at 36 weeks gestation would pose the risk of respiratory morbidity. She maintained that doctors normally would wait and prefer to allow the foetus to develop instead of doing a CS on the mother unless it is absolutely necessary. Since she did not find clear indication for her to do a CS in this case she decided to adopt a conservative management of the first plaintiff. She did so because in her view there was no indication that the first plaintiff was in labour.

[44] In response to the management of the first plaintiff and the concern expressed by Dr Kuppu Velumani, Dr Ong agreed that a baby born preterm at 36 weeks do face the risk of respiratory morbidity and wet lung syndrome. He however was of the opinion that with advances in medical technology the risk is lessened especially in a hospital with a good neo-natal service. On top of it all, Dr Ong was also of the view that there were indications that the first plaintiff was in labour meriting consideration for CS.

[45] In view of the disputes on the issue of a planned CS or otherwise it would be necessary at this juncture to first determine whether the first plaintiff was in fact in labour.

WHETHER THE FIRST PLAINTIFF WAS IN LABOUR

[46] Parties disputed vigorously as to whether on admission or at any time after that, the first plaintiff was in labour. It is the plaintiffs' case that the first plaintiff was in labour at admission or after that and hence a CS should have been undertaken immediately. In contrast, Dr Kuppu Velumani maintained her case that the first plaintiff was not in labour at arrival on the 3 May 2002 morning or any time after that to merit a CS be performed on her before she collapsed.

[47] In order to determine this issue, it would be necessary to evaluate closely the management of the first plaintiff by the Dr Kuppu Velumani on the eventful day of 3 May 2002. It would be necessary in my view to scrutinise them in relation to various stages of management by her of the first plaintiff.

At Admission (6.30am)

[48] The first plaintiff came to the hospital in the early hours of 3 May 2002

with a complaint of abdominal pain. The nurse in attendance reported to Dr Kuppu Velumani of her condition. It was reported that the abdominal pain was of recent onset, her general condition was stable with mild tachycardia, and vaginal examination of her cervix was thick and the *os admitted one finger*. Cardiotography (CTG) tracings recorded from 6.11am to 6.29am (in Bundle BP206) showed normal foetal heart rate and there were no contractions. Keeping in view the information given to her, Dr Kuppu Velumani instructed the staff nurse to administer 75mg of Pethidine and 25mg phenergan by injection, (see medication chart for 3 May 2002 and Records of Nursing Care Bundle B pp 294 & 335).

[49] Though the first plaintiff had abdominal pain, Dr Kuppu Velumani concluded that it was probably caused by stretching of the abdominal muscles. Such stretching according to her normally occurs in woman of 32 weeks gestation onwards. Dr Kuppu Velumani also did not find serious concern requiring her urgent attention at that point in time. The mild tachycardia according to her was due to the pain or the pain along with anxiety in this patient.

[50] This conclusion was also shared with both expert witnesses, Dr Ong as shown in his expert report in exh P1B at para C (i) as well as the testimonies of Dr Raman. Regarding her prescription of pethidine and phenegran, Dr Raman said it is a common sedition used in pregnant women for pain. From the above event and based on testimonies of all witnesses it can be safely concluded that the first plaintiff was not in labour during this period to merit any intervention by Dr Kuppu Velumani.

The first defendant's first visit (8.30am to 8.45am)

[51] Dr Kuppu Velumani first saw the first plaintiff, between 8.30am to 8.45am. In the doctor's clinical notes sheet, she noted her observations on the first plaintiff (see p 325 Bundle B). In her testimonies, she explained that she examined the first plaintiff and found her general condition to be satisfactory. She noted, *gc satisfactory* which denotes the general condition to be satisfactory, she noted there was *no pallor* which means the patient was not anaemic, heart beat at 80 beats per minute (which was an improvement from earlier 108) and her blood pressure was 110 by 70 mm. Dr Kuppu Velumani explained that the first plaintiff's pulse rate came down to 80 beats per minute from 108 per minute at admission. She pointed out that such improvement indicates that her provisional diagnosis of the fact that the pain was caused by stretching of muscles and ligament was proven correct. It also means the analgesic prescribed by her had reduced the pain.

[52] Accordingly, she proceeded to examine the abdomen and recorded her

finding that the baby's head was not engaged. She recorded HNE (head not engaged) in her notes. She palpated the first plaintiff's abdomen and felt mild contractions. She did not find scar tenderness at the earlier CS scar. She did vaginal examination, which showed *OS was 1cm, with cervix thick*. She made a query of labour in her notes. It was because she felt a mild contractions, she ordered another CTG repeat. This is the second CTG tracings, done on the first plaintiff which ran from around 8.50am to 9.10am. From her assessment Dr Kuppu Velumani said, she did not find the first plaintiff to be in labour at that stage.

[53] Dr Ong accepted that there was nothing to suggest that at or around 9am the condition of first plaintiff was not normal, and needed surgical intervention. He further confirmed that the examination for scar tenderness by Dr Kuppu Velumani was appropriate to assess impending rupture of CS scar.

The first defendant's second visit (10.00am)

[54] Dr Kuppu Velumani came again to see the first plaintiff at about 10am. This was her second visit to the first plaintiff. She reviewed the second CTG tracings (Bundle B at p 212).The second CTG according to her, showed mild irritable like contractions, it showed that foetal heart rate was normal and reactive. The presence of mild contractions according to her is no indication of labour.

[55] She then clarified that in her opinion, to be in labour there must be contractions at regular interval with high intensity. She found that the first plaintiff's pain subsided but still she was having some pain. Dr Kuppu Velumani instructed the nurse to take the patient to the maternity ward and to administer bricanyl tablets of 2.5mg. She did so because in her diagnosis, the first plaintiff was in not labour.

[56] Her explanation for giving tablets to the first plaintiff, is to suppress *mild irritable like contractions* According to her, bricanyl tablets are usually given to suppress uterine contractions in premature labour. She emphasised that the tablets prescribed was not intended to stop onset of labour because there was no onset of labour at that point. She explained that bricnayl in tablets does not require close monitoring of mother in foetus and not intravenous bricnayl.

[57] In her clinical note in exh D24, Dr Kuppu Velumani recorded the words *if pain does not subside for LSCS*. Her explanation was that she was planning to observe the first plaintiff to see if she would progress into labour. She said she then had in mind, if the first plaintiff progresses into labour, she would proceed with CS.

The first defendant's third visit (10.45am to 11am)

[58] Dr Kuppu Velumani received a phone call from the nurse whilst she was in her outpatient clinic in the same hospital. The nurse reported that the first plaintiff was complaining of vomiting. Dr Kuppu Velumani instructed the staff nurse to start the first plaintiff on intravenous dextrose 5% and to give her 10mg of maxalon. The dextrose was to counter possible hypoglycaemia and the maxalon was to stop vomiting.

[59] It is to be noted that Dr Ong having examined all the records agreed that at that point, there was nothing to indicate that anything was seriously wrong with the first plaintiff or the foetus. In cross-examination he said there was no necessarily for laparotomy or CS.

[60] Dr Ong however revisited his testimonies the next day of trial to say that yes he agreed with Mr Daryl Goon's question the day before that there was no urgent need for laparotomy. He then qualified his view to say that he believed the option for CS should be considered and he would have proceeded with CS at 36 weeks.

[61] In her notes, Dr Kuppu Velumani noted that she saw the first plaintiff at around 11.00am. The first plaintiff was found to be pale and her pulse was feeble. Dr Kuppu Velumani recalled that sister Amarjit told her that the first plaintiff's blood pressure was not recordable. She re-checked and could not feel the pulse. She checked the blood pressure but could not record any. She immediately instructed the nurse to alert code blue.

[62] Dr Kuppu Velumani recounted the following event in her testimonies as follows. She said one of her nurses rushed with resuscitation trolley. She resuscitated the first plaintiff, instructed the nurse to insert urinary catheter, instructed for six units of blood to be brought to the OT, called Dr Arun to inform about bringing a patient in shock for laparotomy to be proceeded with CS. She also instructed nurses to inform paediatrician to receive baby in the OT. She sent the first plaintiff to the OT at 11.15am for an emergency CS.

[63] Parties are also in dispute as to whether there was resuscitation, or sufficient resuscitation done by Dr Kuppu Velumani. Before I deal with this issue, I would like first to deliberate on the issue of whether the first plaintiff was in labour, prior to her collapse.

EXPERT OPINION ON LABOUR

[64] The opinion of both expert witnesses Dr Ong and Dr Raman was

extensively sought on the issue of whether the first plaintiff was in labour on her admission or anytime before her collapse.

[65] First, there is the evidence of Dr Kuppu Velumani herself on this issue. She testified that that a person is regarded to be in labour *when there is progressive uterine contractions along with cervical changes of progressive cervical dilation*. Progressive uterine contractions according to her means, a person is having contractions starting at one in 20 minutes, then progresses to one in 15 minutes, then to one in ten minutes and reaches one in three minutes just before delivery. She explained that, there would be no labour even if there are regular contractions without progressive cervical dilation. In her assessment the first plaintiff was not in labour, because there were no regular contractions and no cervical dilation.

[66] Dr Ong made a conclusive observation that labour started in the first plaintiff when there was uterine contractions. He concluded that the second CTG tracings in Bundle B, p 212, done at 8.50am shows regular uterine contractions and would constitute sufficient denotation that the first plaintiff was already in labour.

[67] Dr Ong, in cross-examination again reiterated that the second CTG tracings show there was a mild regular uterine contractions. He opined that from the CTG tracings plus the complaint of abdominal pain by the first plaintiff, it was an indication that she was probably in early labour as opposed to established labour. Referring to his written opinion at p 67, Dr Ong testified that in his view, the appropriate management of the first plaintiff at this stage would be to proceed with a CS and he said such is a normal accepted obstetric practice. Pressed further in cross-examination Dr Ong, however agreed that, in this situation the first plaintiff may not progress to labour and *one has to wait and see*. He also agreed that generally in absence of other prevailing factors and with no plan for delivery at 36 weeks one should wait.

[68] Various medical publications and literatures were referred to by both learned counsel to determine, the meaning, the sign and the indication of labour. In exh D13, *Obstetrics Illustrated, by Kevin P Hanretty* (6th Ed) *at p 232* it is stated that labour is recognised by:

(a) *palpable uterine contractions*, regular in frequency and intermittent in character;

(b) *show* — a little blood and mucus discharged from the vagina;

(c) *dilation of cervix* this is accompanied by the formation of fore waters or bag of waters.

In exh D15, a text on *Mosby's Obstetrics & Gynaecology by Derek Llewellyn* —

Jones in collaboration with Suzanne Abrahim and Jeremy Oats, (at p 67) learned author explained that, *onset of labour* is difficult to determine and at most it can be said to be *the time after which uterine contractions cause the progressive dilation of the cervix beyond 2cm, and painful contractions usually occur at least every ten minutes.*

[69] A close examination of Dr Ong's evidence on this issue discloses that in his view the first plaintiff was in labour when he testified in the following terms: *I based my conclusion on the fact that this patient had regular mild uterine contractions — that itself could be taken as the start of labour. It is not necessary for the cervix to be found to be dilated at that stage. The mere finding of uterine contractions would be sufficient for me to make such diagnosis and I stress regular uterine contractions*. Dr Ong was referring to the second CTG tracings of the first plaintiff.

[70] Dr Kuppu Velumani explained that the second CTG tracings, in the beginning show uterine contractions which was about one in four, the next contractions was one in two and the next was one in three, with invariable intensity. Dr Kuppu Velumani made her finding that the second CTG tracings do not show that the first plaintiff was in labour because there were no regular progressive uterine contractions and no dilation of the cervix.

[71] Dr Raman prepared a written opinion which is found in exh D43. In his written opinion Dr Raman, (at para 2 at p 3 of his report) states that the first plaintiff was not in active labour. Dr Raman's explanation on the second CTG tracings is this. There are two components in a CTG. The upper graph denotes a good foetal heart rate between 130 to about 150bpm. The bottom records changes in uterine pressure which shows low grade irregular contractions. Since the second CTG shows contractions which were not regular and of low grade intensity, it is not consistent with labour onset. This is especially so when the vaginal examination showed the cervix dilated only at 1cm and thick.

[72] Dr Raman further elucidated that, the presence of reactive trace with irregular contractions show that the foetus was in excellent condition. In such a condition following the standard guidelines the patient should be reassessed after four hours. This opinion finds support in the guidelines by the Department of Reproductive Health & Research, Family and Community Health, WHO exhibited in exh D46.

[73] Learned counsel for the plaintiffs however maintained that the first plaintiff was in labour. He was also relying, on the literature in exh D16 to support his argument. Exhibit D16 is a textbook by *E Malcolm on Essential Obstetrics and Gynaecology* — (4th Ed). At p 15 under the heading *Onset of Labour*, learned author defines *onset of labour' 'as the time onset of regular,*

painful uterine contractions which produce progressive effacement and dilatation of the cervix. This author concludes that the clinical signs of the onset of labour will include:

(a) the onset of regular painful contractions that produces cervical dilation'

(b) sxhibition of a vaginal show — the passage of blood stained mucus;

and

(c) rupture of the foetal membrane.

[74] Dr Ong relied on the statement in exh D16 that says … *the normal contractions of labour produce thinning and effacement of cervix but do not result in cervical dilation*. Thus, there is no necessity for cervical dilation to indicate labour according to him. However, it is noted that the statement above is made by the author in relation to cases of cervical stenosis. In Dr Ong's observation, labour can start by the finding of regular uterine contractions alone. According to him cervical dilation is not a necessary ingredient. He reiterated that there were contractions shown in the second CTG of the first plaintiff.

[75] On the other hand, according to Dr Raman in the second CTG tracings there was no regular contractions recorded, it is merely an irregular like irritable uterus. Dr Raman was of the view that, with no regular contractions recorded, coupled with the fact that there is no cervical dilation, he is convinced that the first plaintiff was not in labour.

[76] The various text books and publications tendered on this issue supported the view of Dr Raman. In exh D12, it is stated at p 293 that the only real proof that labour is established, is the progressive dilation of the cervix. Exhibit D12 is a textbook by D Keith Edmonds on *Dewhursts Textbook of Obstetrics and Gynaecology for Postgraduates*, (6th Ed). Learned author further states that women diagnosed to be preterm labour are not treated and 62% had not delivered after 48 hours and 34% went back to term. In exh D44 at p 348 it states that the *start of normal labour is difficult to define precisely although it is often cited as being from the onset of painful uterine contractions that are associated with effacement and dilation of the cervix beyond 3cm with descent of the head in a vertex presentation*. The same observations are also found in the other literature in exh D13. Exhibit D13 is a book entitled *Obstetrics* illustrated by Kevin P Hanretty, (6th Ed).

[77] Dr Raman defines labour as *a regular uterine contractions with progressive dilation* and agreed with learned author in exh D16. In exh D16, learned author observed that it is often difficult to be certain of the exact time of onset of labour because of the occurrence of *false labour*. According to the author, false labour occurs where there is onset of painful contractions which is not

A associated with progressive dilatation of the cervix. Dr Raman agreed with the author's view in exh D12 that many people intervene to treat preterm labour based on regular uterine contractions alone. In his view both CTG tracings of the first plaintiff do not show uterine contractions and it is not possible even to make provisional diagnosis of labour. Furthermore, he said there is no evidence B from the notes nor from evidence testified in court in the course or trial where he was present throughout, that suggests the first plaintiff was in labour. He therefore disagreed with the opinion of Dr Ong who testified that the first plaintiff was in labour based on contractions alone especially because there is no intensity in the contractions.

C

[78] Learned counsel for the plaintiffs contended (relying on D12) which states that, it is true that the only real proof of labour is progressive dilation of the cervix, because in D12, learned author continued to say that once that D happens, it is too late to take any preventive treatment. Thus, Encik PS Ranjan contended that diagnosis has to be made on the basis of reported uterine contractions. He further relied on exh D13 which states that progress in labour is gauged by increasing strength, frequency and duration of uterine contractions and dilation of cervix.

E

[79] Upon my careful scrutiny of Dr Ong's evidence, what he said was this. First, he suggested that labour can be diagnosed solely on the basis of uterine contractions in his testimonies recorded at p 145 of the notes of evidence. In answer to a cross-examination put to him, he said there must be regular uterine F contractions. He took the view that the first plaintiff was in labour because … *there was definite presence of regular uterine contractions* in the second CTG tracings. When in fact, the second CTG tracings of first plaintiff, show irregular contractions of the uterus, and good foetal heart rate. At the end of it all I find Dr Ong's evidence rather confusing when he concluded that the G second CTG shows the first plaintiff was in labour. In my view, when he concluded that the first plaintiff was in labour relying on the second CTG, where there were mild regular contractions Dr Ong was prevaricating the issue of labour. It is a fact that there were no regular contractions in the second CTG tracings as we can see from the charting.

H

[80] Having examined the cited publications above, I am inclined to accept the evidence of Dr Raman as well as the testimonies of Dr Kuppu Velumani that the first plaintiff was not at any time in labour. In my view the testimonies of Dr Raman are well supported by the literature on the definition of labour. In I both exh D16 and D12 the learned authors make it clear that an onset of labour must always be presented with uterine contractions plus dilation of cervix. In fact in D15, learned author Derreck LLewelly-Jones in *Obstetrics & Gynaecologists* observed that onset of labour is difficult to determine with accuracy and at most it can be said as, the time after which uterine contractions

cause the progressive dilation of the cervix beyond 2cm with painful contractions usually occurring at least every ten minutes.

[81] It appears that both parties sometimes do rely on the same literature and publications. However learned counsel for the plaintiffs had not referred to them in their right context. There was nothing in all these publications that have placed reliance on contractions alone without dilation of cervix to indicate labour. All the literatures cited in fact, accepted the position that the contractions must be regular and progressive to establish that a patient is in labour. None of which was present in the first plaintiff at any given time.

[82] It is noted that in the course of trial the witnesses had been referring to the terms *early labour, established labour, active labour,* and *established pre term labour*. Dr Ong agreed that the first plaintiff was in early labour based on second CTG tracings but yet agreed that she may not progress to labour at the end. He in fact uses *probably early labour* at p 66 of his written opinion. Finally, Dr Ong makes a distinction between early labour and established labour.

[83] Dr Raman explained *active phase of labour* to mean a phase where cervix dilates to more than 3–4cm with contractions. He explains *latent phase* of labour is where the cervix dilates less than 3–4cm with contractions. He further explained that *latent phase* does not progress to *active phase*. To be in labour, a person has to be in the *active phase*.

[84] Perusing through all the publications cited on this issue plus the evidence of both medical witnesses and expert opinion by Dr Raman, I agree with the defendant that, on the facts of the present case there is no presence of labour in the first plaintiff. This is because there was no regular uterine contractions and dilation of her cervix, for any conclusive evidence that she was in labour.

[85] The plaintiffs further mounted criticism on the lack in labour charting or partogram by Dr Kuppu Velumani. Such failure was taken to suggest to have caused her failure to detect that the first plaintiff was in labour. Dr Ong commented in his report that this failure was not an appropriate management of the patient by Dr Kuppu Velumani. In fact according to him in a patient with previous CS her blood pressure and pulse should be monitored half hourly or hourly. Since there was no BP/pulse chart of the first plaintiff during this period in time, he could not appreciate what was her BP and pulse rate while she was in the ward on 3 May 2002.

[86] Dr Raman in his evidence explained that labour charting is only necessary to be commenced when a patient is in labour. He was referred to exh D45, which supported his view that a partograph chart must only be started

when a women is in established labour also known as the active phase of labour. According to him, this is a standard practice. Exhibit D45 is a publication by the Royal College of Obstetricians and Gynaecologists entitled *Life Saving Skills Manual*. Appendix 2 of the publication, explains on how to use partograph.

[87] In any event from the first CTG to the second CTG there was no indication that the first plaintiff was in labour. Following the expert opinion of Dr Raman and the literature in exh D45, there is no valid criticism against Dr Kuppu Velumani for not starting partograph charting. Thus the criticism by Dr Ong that there was no labour charting will only hold good if the first plaintiff was in labour.

THE NOTATION LSCS BY THE FIRST DEFENDANT

[88] Learned counsel raised issue and criticised the notation made by Dr Kuppu Velumani which states *if pain subsides for LSCS ~~today~~*. In her own writing, Dr Kuppu Velumani deleted the word *today*. She explained the reason why she wrote *for LSCS* was because, in her mind, if this patient eventually goes into labour she would have proceeded with LSCS. According to her, if such were to happen it means that, her attempt to eradicate mild irritable like contractions did not work. She was in fact observing if the first plaintiff would progress into labour at all.

[89] Mr PS Ranjan also questioned Dr Raman why Dr Kuppu Velumani noted *if pain does not subside for LSCS*. Dr Raman said he cannot comment but opined that she probably would wait till the cervix dilates 3–4cm to do CS.

[90] In view of the explanation given I cannot infer anything sinister on this notation. In saying this, I give my due consideration to the testimonies of Dr Kuppu Velumani, Dr Marlik and the evidence of the other doctors that, the notes of doctors are sometimes done in pressing and emergency situations. There are times when doctors' notes are written after the procedures are completed. These then became their recollections of the events that had taken place. Thus failure to note events and procedures in minute details can be excused. Variance in time is likely to occur in emergencies and it is therefore not unreasonable for time recorded to be inexact. In fact, it is a fallacy and devoid of common sense to insist on exact time, to be noted. It would not be wrong for me to surmise that all the doctors testifying in the trial were in chorus that entries by nurses and doctors are approximations, emergency records of time entries are made after the event. Doctors and nurses will try and recall as accurately as possible (as stated in the testimonies of Dr Ong, Dr Raman, and Dr Lim on this issue). Even the watches of doctors and nurses would not be

synchronised everyday and this clause can cause some discrepancies in charting and recording of time in the medical records.

[91] The more important consideration is to look at the effect and the management of the patient in itself.

AMENDED DEFENCE

[92] Encik PS Ranjan raised issues on the amendment of the defence made three times by the defendants. The original defence pleaded by the first defendant was that the first plaintiff was *not in labour*. It was amended to *not in active phase of labour*. Later the defence was again amended back to *not in labour*. The explanation suggested by Dr Raman was that lay person uses the term *early labour* in the first plaintiffs condition but he maintained that until a dilation of 3–4cm takes place, a person is not in labour. In his view the terminology used in the defence, which were amended and re-amended in fact does not make any difference as the first plaintiff was in fact not in labour.

COLLAPSE OF THE FIRST PLAINTIFF AND DELAY

[93] The plaintiff mounted a case of delay in the management of the first plaintiff by Dr Kuppu Velumani. It is the plaintiffs' case that CS should have been done on the first plaintiff at 10.00am the plaintiffs relied on the evidence of Dr Marlik and argued that 15 minutes time taken, to bring patient from the ward to the OT is a delay. The plaintiffs contended that Dr Kuppu Velumani gave various inconsistent records of time on the events. The plaintiffs argued that if time is approximation it should be so stated in the report or notes. The plaintiffs contended she should have attended and came up to the see the first plaintiff right at 10.30am when she received the first phone call from the nurse.

[94] The events preceding the collapse of the first plaintiff as disclosed in the course of trial are these. Dr Kuppu Velumani said she received a call from the nurse that the first plaintiff vomited. In the nursing report at p 328 of bundle B the notes by the nurse states that at 10.30am there is an entry *T/O from LBR* which means the patient was transferred from labour room, corresponding with the instruction of Dr Kuppu Velumani's earlier visit around 10am Upon receiving report that the first plaintiff was vomiting, Dr Kuppu Velumani instructed for the first plaintiff to be given intravenous dextrose and maxalon to stop vomiting.

[95] The plaintiffs' case is that Dr Kuppu Velumani delayed in responding to the telephone calls made by nurses. Nursing record (exh 1 p 19) shows that the nurses made two telephone calls, one at 10.30am and another at 10.50am. In her record, Dr Kuppu Velumani noted in her notes that she came to the first

plaintiff at 11.00am. Mr PS Ranjan contended that this shows the delay by Dr Kuppu Velumani in attending to the first plaintiff. By that alleged delay, relying on the expert opinion of Dr Ong that the first plaintiff was in labour a CS should have been performed on the first plaintiff at least at 10.30am. He submitted that if that was done the whole episode could have been avoided.

[96] When these facts and evidence are juxtaposed what is clear is that, during the period between 10.30am to 11am telephone calls were made to the first defendant by the nurse. According to the nurse's records there were two telephone calls made. The first was at 10.30am In this telephone call, the nurse informed the Dr Kuppu Velumani that the first plaintiff was in pain and vomited. Dr Kuppu Velumani ordered intervenes drip of 5% dextrose and maxalon (anti drug for nausea). The drugs were administered as instructed.

[97] Another call was made by the nurse at 10.50am to inform Dr Kuppu Velumani that the patient was still in pain. She then came to see the first plaintiff as shown in the nurse record at 10.55am. In Dr Kuppu Velumani's report, it was noted to be at 11am The first defendant was severely cross-examined by Mr PS Ranjan on the discrepancies in time between Nurse's records and the doctor's record not only on this episode but almost throughout the course of trial whenever such discrepancies arise.

[98] The explanation by the Dr Kuppu Velumani repeatedly in the course of the trial plus a few other medical witnesses is that *time* recorded in the entries cannot be exact in the circumstances and they are always mere approximations. This is because doctors do not normally jot down time before taking steps in the management of patient. It is not possible in all circumstances that time can be accurately recorded because doctors need to attend to emergencies at hand before putting the events on record.

[99] In my view this explanation is acceptable and reasonable. Whilst I agree with learned counsel that records are important to be accurately kept, surely attending to patient is always priority. As records are then put to papers at the end of an episode it is acceptable that detailed information may be missed out.

[100] Quite apart from record keeping, in my view, the more important thing to be looked at is whether a proper management of the patient had indeed taken place. This is shown on the result and impact on the patient. Hence, the failure to note or record certain event need not necessarily conclude that such treatments are not administered on the patient. The outcome or the result of certain administration or management on the patient would have to be placed importance, rather than purely relying on the records and account made by nurses or doctors. It is therefore important to keep in view this information in analysing the treatment given by the defendants.

[101] Having appraised with all the relevant evidence, I now come back to the contention of the counsel for the plaintiffs that Dr Kuppu Velumani should have performed the CS on the first plaintiff at 10.00am or 10.30am, relying on the opinion given by Dr Ong. Upon my scrutiny of the opinion of Dr Ong again, and I take note that in para 3 at p 67 of the report he opined that a CS was to be done because in his view the second CTG tracings shows a regular uterine contractions and the patient was in fact in labour. In fact if the prognosis of labour is solely based on uterine contractions alone and not even regular contractions the first plaintiff can be said to be in labour even as early as 8.50am. Having agreed with the opinion that labour has not commenced in the first plaintiff the proposition that there should be CS done at 10am does not hold good.

[102] In my view the alleged delay should be measured from the time the patient collapse (which was recorded at 10.55am) to the time she was taken to the OT for CS which is recorded to be at 11.15am. This in the opinion of Dr Raman is well within accepted practice. In the final analysis the fact that the first plaintiff was taken to the OT in less than 30 minutes from her state of collapse is an acceptable practice according to Dr Raman. I am therefore not able to appreciate the suggestion of the counsel for the plaintiffs that the time used to suggest computation of delay must be computed from 10.30am. when the patient complained of pain and vomiting. Even if the Dr Kuppu Velumani were to come up to see the patient at 10.30am in the ward by her own observation she would not have brought the patient for a CS at that time because the first plaintiff was not in labour. It was only when she collapsed at 10.55am that the need for CS arose.

[103] Learned counsel for the plaintiffs knick picked issues with the first defendant on some little point. Dr Kuppu Velumani in her testimonies said when the phone calls came she was in her outpatient clinic. Because she had to leave her outpatient to attend to the first plaintiff, she had told them that she had to attend to an emergency. By which remark, learned counsel for the plaintiffs took to imply that, in spite her knowing that the first plaintiff's case was indeed an emergency (that required urgent attention) Dr Kuppu Velumani took her time. Despite explanation made by Dr Kuppu Velumani that she said so to justify her leaving her out patient waiting, learned counsel had used the statement of Dr Kuppu Velumani to support his submission that she was not giving attention to an emergency case of the first plaintiff. This was one reason cited to support an accusation of delayed attention given to the first plaintiff by Dr Kuppu Velumani. It was contended by Mr PS Ranjan that because there was delay by the first defendant in coming to see the patient's deteriorating condition, CS was delayed. If she had come immediately at 10.45am, a decision to perform CS could have been made earlier and the delivery of the baby would have taken place by 11am or even earlier instead.

[104] The first defendant always maintained her position that, a CS would only be performed on the first plaintiff, if she was found to be in labour. However, an emergency CS had to finally be performed on her because she collapsed. This leaves the first defendant with practically no choice in order to save both the mother and the baby.

[105] The contention of learned counsel that CS should have been performed at 10am in my view is hindsight wisdom. We are here more concern with fore sight of a reasonable medical practitioner in the circumstances presented. This is the principle stated by Lord Scarman in *Maynard v West Midlands Regional Health Authority* [1985] 1 All ER 635 when he said *It is not enough to show that subsequent events show that the operation need never have been performed, if at the time the decision to operate was taken it was reasonable in the sense that a responsible body of medical opinion would have accepted it as proper.* We now know, after the event that the first plaintiff collapsed at around 11am. It can now from hindsight perspective be viewed that a CS upon collapsed is a delay. However since the first plaintiff did not present herself in a state of labour, there was no reason that an emergency CS would have to be performed anytime earlier. In view of that, a reasonable medical practitioner would not perform a CS in absence of labour. Thus the criticism that an earlier CS should have been done is clearly baseless.

RESUSCITATION

[106] The plaintiffs asserted that Dr Kuppu Velumani was negligent in the management of the first plaintiff when her records do not show that she resuscitated the first plaintiff upon her collapse. The allegation is premised on the following:

(a) there was no record made in first defendant's notes that she resuscitated the patient before sending her to the OT;

(b) the notation by Dr Ami in the OT notes that he, with the help of Dr Azhar did the *initial resuscitation* showed that the first plaintiff was resuscitated only in the OT;
and

(c) the opinion of Dr Ong that the resuscitation was not done properly because the record showed that the patient was in a decomposed state with hypertension and tachycardia from 10.55am to 12pm
(ie for more than 65 minutes).

[107] Dr Kuppu Velumani in her testimonies said, the first plaintiff was resuscitated immediately in the ward upon her collapse. She admitted that she made no record in her notes, that she resuscitated the first plaintiff. Nevertheless, she maintained that she resuscitated her upon her collapse. In

support of her claim, she pointed out the records in exh D51 which recorded two units of haemacel were used in the maternity ward. D51 is a hospital record of pharmacy items used by the patient in the ward. It was explained by both Dr Raman and Dr Kuppu Velumani that haemaccel is a colloid used for resuscitation to prevent hypovolemia due to large loss of blood.

[108] Mr PS Ranjan relied on the notes (in Bundle B p 82) by the anaesthetist, Dr Azhar (fourth defendant) to show that initial resuscitation in fact only commenced in the OT. Dr Azhar in his report explained that the patient arrived at 11.15am. At para 2 of his report, he states that: *my involvement in this patient's management was helping Dr Arul who was the primary anaesthetist in the initial resuscitation of the patient*. Now, can this statement shows that in fact the initial resuscitation only commence at the OT. Reading this report plainly, what it simply says is that Dr Azhar helped Dr Arul with the initial resuscitation of the first plaintiff in the OT. It should not be taken out of context to prove more that the plain language of the report says. Without even going into any other evidence, in my view this note cannot be taken to mean that the initial resuscitation of the first plaintiff has only commenced by Dr Arul in the OT. It was only good to show what it says, that Dr Azhar was assisting Dr Arul's initial resuscitation in the OT.

[109] In the light of all the above evidence I am inclined to accept the defendant's case and her evidence that there was resuscitation in fact done. My reasons are these. First, there is record on the use of haemaccel in the ward shown in exh D51. Since haemaccel is only used for the purpose of resuscitating a patient and nothing else it goes to support her case that she used them to resuscitate the first plaintiff. Secondly, Dr Kuppu Velumani's report at B-24 in the first para states that … *At the time the patient's blood pressure and the pulse was not recordable. Resuscitative measures were done at the same time* … Thirdly, it is a fact that the first plaintiff had an unrecordable BP in the ward. Upon arrival at the OT her BP was recordable and according to Dr Arul's report (at p B-80), the patient was semi-comatose, with pulse rate of 160/min and systolic blood pressure was 40/mmHg. It was explained by Dr Raman that from an unrecordable state to a recordable state upon arrival at the OT, it shows that resuscitation must have taken place, otherwise her BP would not read at Systolic BP of 40/mmHg, on arrival at OT. The fact that the first plaintiff's BP was recorded at 40m/Hg from a non recordable state shows that resuscitation measure was undertaken.

[110] There is eye witness of resuscitation taking place. When Dr Marlik responded to code blue call, he rushed to the ward. He saw the intravenous line on the patient. He saw fluids were pushed into the patient in the ward.

[111] Dr Sylvian Dass (PW7) a consultant anaesthesiology intensive care

and pain management at PMC, Bangsar testified as an expert witness brought by the plaintiffs. PW7 is of no assistance to the plaintiff's case on this issue. He in fact concluded in his opinion that Dr Arul and Dr Azhar resuscitated the patient adequately. He confirmed that colloid should be used for resuscitation. He pointed out that there was no record shown by Dr Kuppu Velumani that she resuscitated the first plaintiff. In cross-examination he was referred to Bundle G p 3 to comment on the notation in the anaesthesia record which states under the column previous anaesthesia as *Resuscitation-OT*. His comment was that this notation in indicative of patient being resuscitated and then sent to the OT. In re-examination he further confirmed in response to the counsel's question whether Resuscitation-OT is accepted term to say that resuscitation was done before going to OT.

[112] Dr Slyvian Dass however supported the contention of the plaintiff's Counsel that if indeed resuscitation had been done it should be properly recorded by Dr Kuppu Velumani and in fact it should be given to the anaesthetist in the OT. This was not done in the present case.

[113] It was also submitted by learned counsel for the plaintiffs that both Dr Arul and Dr Azhar were not called by the defendant to confirm this issue. I find no legal burden to be imposed on the defendant to prove that initial resuscitation was done by Dr Arul and Dr Azhar. The defendant's case is that Dr Kuppu Velumani resuscitated the patient in the ward and it was the plaintiffs who asserted that resuscitation only commenced in the OT by Dr Arul and Dr Azhar. The plaintiff is at liberty to subpoena these two doctors to testify because the plaintiffs owe the legal burden of proving what the plaintiffs want to assert and not the defendant.

[114] The plaintiffs further took a view that even if resuscitation did take place; the resuscitation was not adequately done. In this respect I find that the evidence of Dr Raman had added clarity on this point. First according to Dr Raman there is no need to set up two or three drips to infuse fluids, because in a collapsed state it is difficult to infuse fluid fast enough. Thus even if there was no evidence of two or three drips in the patient it cannot be taken to indicate that infusion of fluids did not take place. He nevertheless agreed that the first defendant should have noted that she had undertaken resuscitation in her notes. The failure of not making such notation cannot conclude that there was no resuscitation. There is other evidence according to him that cannot be ignored, which show that the Dr Kuppu Velumani did resuscitate the first plaintiff. He explained that if we look at the report of the Dr Kuppu Velumani in B24 it is clearly stated that resuscitation was done in the ward. This report shows that the first plaintiff recorded a BP of 40/mmHg with pulse of 160 per minute in the OT. Dr Raman explained that this cannot happen if no fluid was infused in the first plaintiff in the first 15 minutes from her collapse. In fact, in

the opinion of Dr Raman, if the first plaintiff was not infused with fluids in the maternity ward, she would have had a cardiac arrest from severe hypovolemia by the time she arrived at the OT.

[115] In cross-examination Dr Raman agreed that at the BP at 40/mmHg, is extremely low. He also agreed to the proposition by Mr PS Ranjan that even without resuscitation, the body's compensatory mechanism can bring up the BP. However, he said it can only be up to a point of 30% of blood loss of total blood volume in the body. He went on to explain that in a pregnant woman the blood volume is 100 ml per kg. In the case of the first plaintiff whose weight was about 60kg she would have a blood volume of 6000ml. Her recorded blood loss was 2.5 litters. According to him with that kind of proportion, the capacity of natural mechanism to increase blood pressure would fail, unless fluid is infused.

[116] Even at the suggestion that some pregnant woman may be tougher and may be able to withstand massive blood loss more than the other, Dr Raman maintained his view that nobody can withstand a loss of 2.5 litters of blood (as found in the abdomen) in this case. In fact, he said after 2 litters of loss without resuscitation a patient can be dead in less than five minutes.

[117] Dr Raman also reminded that, there cannot be a successful resuscitation in this case because whilst resuscitation was taking place correspondingly the patient was continuously bleeding. A two prong approach would therefore be required. There must be resuscitation and a hysterectomy performed at the shortest possible time to arrest continuous bleeding. The initial resuscitation was sufficient according to him to ensure that the heart will not stop, when general aesthetic is administered on the first plaintiff for the operating procedure. Thus, he concluded that in the circumstances of the present case no adequate resuscitation defined as BP above 90/mmHg systolic can ever be achieved.

[118] In conclusion, based on all the evidence of witnesses including the expert opinion given on this issue I have no hesitation to accept the version of the first defendant's case that she did resuscitate the first plaintiff upon her collapse before sending her to the OT. The failure to record such procedure cannot nullify this fact. The result on the patient clearly supported the case of the first defendant that she resuscitated the first plaintiff upon her collapse. Hence there is no breach of duty or negligent on her part in the handling of the plaintiff after the collapse.

DELAY IN MANAGEMENT FROM TIME OF COLLAPSE

[119] The next issue raised was that there was a delay in resuscitation that

had caused catastrophic injuries to the baby. On this, counsel for the plaintiffs contended that a delay in resuscitation after collapse would be disastrous. Responding to this allegation Dr Raman explained that generally, a baby's ability to withstand hypoxia is quite good. He referred to an article in exh D50 is an article from *Journal of Clinical Obstetrics & Gynaecology* Vol 45 No 2 pp 377–392 on *Maternal and Cardiac Arrest in Pregnancy.* Based on a table (shown as table 7 at p 389) Dr Raman explained there are cases where a mother's heart stops for between 26–35 minutes; 1/4 or 25% of babies survive, in the category of mothers' heart rate stop for between 16–25 minutes 1/3 survivals and were born normal, for the category of where heart stops for six to five minutes 83% survived and born normal. A foetus of 36 weeks in this case according to him has a good chance of survival independently even if there was a delay in the resuscitation.

UTERINE RUPTURE OR PLACENTA PERCRETA

[120] I now come to another heavily disputed area between the parties. Parties were at variance on the cause of bleeding occurred in the first plaintiff, which had caused her eventual collapse.

[121] As I have earlier alluded to, the plaintiff insisted that there was *uterine rupture* that had caused the bleeding and the eventual collapse of the first plaintiff. Mr PS Ranjan submitted that *uterine rupture* is a foreseeable condition because of the first plaintiffs history of CS due to CPD in the earlier pregnancy. He submitted, Dr Kuppu Velumani should have foreseen this and should have been able to prevent *uterine rupture* from happening. The pleaded case of the plaintiffs in the statement of claim alleges that the first defendant had allowed *uterine rupture* to occur. In support of this contention learned counsel for the plaintiffs relied on the records in some of these documents. Dr Navinbhai Patel's pathologist report in B18 states *tear in the wall of funds, uterine wall around perforation* and *tear in the uterus with wall at fundus*: In the notes of the Paediatric DW5 (Dr Haliza) sent to Selayang Hospital (see Bundle B189) as well as the notes of Dr Arul in Bundle B p 323). The testimonies of both the first plaintiff and her husband saying that the first defendant told them of ruptured uterus, after the operation.

[122] For the defendant, it was contended that the bleeding in the first plaintiff which caused her eventual collapse was because of the abnormal presentation of her uterus called *placenta percreta*. This condition is not foreseeable by the first defendant. The first defendant said the plaintiff's collapse was due to massive bleeding because of plaintiffs abnormal presentation of uterus of the rarest kind call *placenta percreta*. This condition had caused her vessel at the fundus to rupture. It was associated with *placenta percreta* which caused massive bleeding at the placental site that caused the

collapse of the plaintiff. The blood vessel and the surface of her uterus suddenly burst leading to a sudden event of collapse.

[123] Any further discussion on this issue cannot be appreciated without first analysing the basic meaning of these two terminologies in the *Obstetrics and Gynaecology sense*.

[124] I will first deal with the term *uterine rupture*. Dr Marlik defines *uterine rupture* to mean that there is a breach throughout the whole thickness of uterine wall from the exterior most, through the muscle wall of the uterus called myometrium and through the other side called endometrium. For a uterus to rupture the entire wall must be breached exposing the uterine cavity to the abdomen according to Dr Raman. Dr Raman further added that if a tear in the uterine wall is not such that it is a tear that goes right through the wall creating a passage through the uterus then it is not *uterine rupture*.

[125] The defendants' case is that the first plaintiff was suffering from an abnormal presentation of the placenta. A normal placenta is implanted onto the inner most layer of the uterus, the desidua (as depicted in the diagram exh as D3a). If a placenta is implanted beyond the deciduas, the presentation is abnormal. There are three categories of such abnormalities of the presentation of uterus and they are;

(a) *placenta accreta* is where the placenta is implanted in the myotrium depicted diagrammatically in exh D3b

(b) *placenta increta* is where the placenta grows into the myotrium as depicted in exhibit D3c

(c) *placenta percreta* is where the placenta grows beyond myotrium through the whole of the wall of the uterus, as depicted diagrammatically in exhibit see D3d.

[126] The first plaintiff according to the defendants was suffering from an abnormal presentation of the placenta of the third category above. It is a condition where her placenta had grown through the wall of her uterus as depicted in the diagram shown in exh D3d.

[127] Dr Marlik demonstrated the condition of abnormal presentation suffered by the first plaintiff in court using model made of plasticine. Dr Marlik explained the rarest abnormal presentation being in exh D3d and is known as *placenta percreta*. *Placenta percreta* at the fundus as opposed to CS scar is even rarer. According to Dr Marlik this is the condition suffered by the first plaintiff. Dr Ong also confirmed that *placenta percreta* at the fundus is indeed rare. Dr Ong in his testimonies confirmed these three categories of abnormal

presentation of uterus. He agreed that the pictures in exhs D3b, D3c, and 3bd show the three categories of the abnormal presentation of the placenta. Dr Ong at the same time confirmed the difficulty in diagnosing *placenta percreta* before delivery of the baby.

[128] I now come to the evidence relied by the plaintiffs. The plaintiffs essentially relied on the following evidence to support a case of *uterine rupture*:

(a) The evidence of the first plaintiff herself, who testified that she was explained by Dr Kuppu Velumani that her internal organ burst.

(b) The husband's evidence that Dr Kuppu Velumani showed him the uterus placed in a container. He was shown the ruptured part of the uterus and was told by Dr Kuppu Velumani that this is a one in a million case.

(c) The evidence of Dr Ong's where he opined that in his opinion the cause of collapse was related to *uterine rupture* as a result of *placenta percreta*, which resulted in severe intra abdominal bleeding (exh P1B).

(d) There following lists of documents that refer to *uterine rupture*:

(i) in exh B20, a report by Dr Malinee Thambyah made in reference to the second plaintiff refers to *ruptured uterus*;

(ii) a written report in exh P20 by Dr Rajimin S Sivanesan (PW6) makes reference ruptured uterus in his written report;

(iii) an entry made by Dato' Dr Rani a neurologist, that in Bundle F p 24 there was an entry *Pre-partum anexia secondary to uterine rupture*;

(iv) the anaesthetist Dr Arul uses *rupture of uterus;*

(v) a nurse note which states *rupture uterus;* and

(vi) note by paediatrician Dr Haliza noted *ruptured uterus*.

[129] Before going into the various evidence listed above, one has to bear in mind that the issue confronting this dispute involves a technical medical term in the area of obstetrics and gynaecologists. Thus it is crucial to pay attention to sound medical finding based on empirical evidence in arriving at a particular definition. Having said that, from the testimonies of all medical witnesses it can simply be summed up that, the term *uterine rupture* used in the obstetrics and gynaecologists sense is a sudden tear or bursting in the wall of the uterus which will normally result in severe catastrophic haemorrhage, compromising patient's vital signs.

[130] The evidence relied upon by the plaintiff in the proceeding paragraphs to support a case of *uterine rupture* now must be weighed against the evidence of the defendants in establishing a case of *placenta percreta*.

[131] Available before the court are the testimonies by the first defendant as well as the second defendant. They both are the doctors performing the CS and therefore are eye witnesses to the condition of the uterus of the first plaintiff. Both the Dr Kuppu Velumani and Dr Marlik are experienced obstetrics and gynaecologists who in my view are persons who are not unfamiliar with the issues confronting us. Despite their positions as defendants in this case I see no reason why I cannot accept their evidence on their medical opinion. I am guided in doing so by the decision of *Krisnan Nambiar s/o Prabakaran & ors v Dr P Mahendran & Anor* [2009] 4 MLJ 267; [2008] 10 CLJ 215 where Low Hop Bing J held a view that there is no law that prohibit treating doctors evidence from being admitted and no law that presumes a treating doctor's evidence lacks objectivity. In fact he stressed the point in that case that the opinion of a doctor examining the patient in that case should be preferred to the opinion of the other doctor which was based on injury report or x-ray report without looking to the x-ray plate.

[132] Both the first and the second defendant testified that there was no *uterine rupture*, based on what they saw during the CS procedure. Dr Marlik testified that during the operation he could see that the bleeding in the first plaintiff was from the vein and venous structure at the margin where the placenta had gone through.

[133] This evidence is supported by the pathologist in the pathologist report by Dr Navinbhai Patel. Pathologist Dr Navinbhai Patel testified as DW4. Dr Navinbhai Patel is the pathologist who prepared the pathologist report of the specimen sent to him in relation to the first plaintiff. His report is as shown in Bundle B p 18. Dr Navinbhai Patel had been in practice for 20 years. In his oral testimony in court he said he examined between 10% to 12 % post-partum uteri per year.

[134] He explained that the specimen sent to him is compatible with the condition *placenta percreta* of the uterus. He testified that in this case, the placenta had grown from inside through the uterine wall into the muscle, in fact, through the entire thickness of myometrium. *Placenta percreta* according to Dr Navinbhai Patel is a condition where the placenta grows through the wall of the muscle layer. It will damage some of the muscles and just grow through but in the process it will rupture some of the smaller vein. When it grows through the uterine wall it will not cause catastrophic bleeding.

[135] Dr Raman also confirmed that there is no evidence of *uterine rupture* in this case. For a uterus to rupture according to him, the entire wall must be breached exposing the uterine cavity to the abdomen. If there was rupture of the uterus in the first plaintiff, it would be impossible for the two experienced obstetricians operating on her to miss it. In cross-examination Dr Raman was

A referred to statement made by Dr Ong which says that collapse of the first plaintiff was related to *uterine rupture* resulting from *placenta percreta*. Dr Raman commented, in a *placenta percreta* where there has been a *uterine rupture* the cavity of the uterus has to be exposed completely to the peritoneum. He said in the present case, the placenta prevented this from happening and the B lining of uterus was never exposed. That was his explanation when he concluded that there cannot be *uterine rupture*.

[136] Returning to the evidence relied by the plaintiffs. First the doctor's C note at 11am on 3 May 2002 states the possible cause of collapse was recorded as *'rupture uterus'*. The discharge summary was noted with diagnosis of *'ruptured uterine vein with placenta percreta'*. In the consent to treatment form, signed by the husband for the emergency hysterectomy, it is recorded that the husband was explained on the seriousness of the patient rupture of the vein on the wall at the fundus. Bearing in mind that the terminology *uterine rupture* D requires specific assessment in the obstetrics and gynaecologists sense, one has to rely on the technical evidence which must be of some empirical value to understand this term.

E **[137]** The reliance of the plaintiffs on the evidence listed such as the testimonies of the first plaintiff based on the information given to her by Dr Kuppu Velumani hardly explains the condition. Even the evidence of the first plaintiff's husband who was shown the actual uterus with ruptured part in my view cannot be relied. As to all the notations by various doctors quoted above F by the plaintiffs, in my view cannot support the contention of the plaintiffs, because they are not obstetrics and gynaecologists doctors with specific knowledge in the area in question. The evidence tendered by the plaintiffs, to show that there was *uterine rupture* was therefore of very little value to establish such a specific medical finding.

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[138] The first defendant's case is that the first plaintiff has her placenta grown into the wall of the uterus at the top (fundus) through the other side presenting a condition called *placenta percreta*. This condition according to the expert evidence of Dr Raman cannot be detected, even with advance imaging H techniques. Dr Kuppu Velumani testified that *placenta percreta* cannot be detected by routine antenatal examination, and there is no fool proof method, other than by way of surgery. Dr Ong in his evidence acknowledged the difficulty in detecting *placenta percreta*. In this case, the *placenta percreta* was in fact attached at the fundus of the uterus which is even more difficult to detect I than if it has been at the lower segment where CS scar is found.

[139] Dr Marlik said *placenta pecreta* is a very rare condition. It cannot be detected unless there was suspicion earlier that the placenta had been implanted in the lower segment in a previous CS. He stressed the point that

placenta percreta at the fundus as in this case is even rarer because it does not give out symptom. The pathologist Dr Navinbhai Patel confirmed the rarity of this condition when he testified that, in the last 20 years of practice as pathologist, he had only seen one of such a case, which is the present case.

[140] The testimonies of all the witnesses above are in line with the cited literature and the publications on this subject. Learned author CH Comstock (exh D4) confirmed that there is no completely sensitive and specific test for the diagnosis of the *placenta accreta*.

[141] From the above evidence it is clear that the abnormal representation of the first plaintiff uterus of *placenta percreta* is not detectable upon routine antenatal check up. The detection of *placenta percreta* can usually happen only after delivery of baby when the placenta cannot be delivered easily. The expert evidence of all witnesses also confirmed that it cannot be detected even, through advanced imaging equipment. The case of the first plaintiff is made worse because it occurred at fundus.

[142] This evidence lend support to the case of the defendants that the intensive bleeding in the first plaintiff which caused her to collapse was due to intensive bleeding contributed by sudden event due to the bursting of blood vessels. It is also in the testimonies of Dr Raman that *placenta percreta* itself does not cause pain, otherwise the first plaintiff would have suffered pain long before. This is because the placenta takes time to grow through the uterine wall. It is a slow growing process.

[143] From all accounts, it is obvious that the first defendant cannot be expected to detect the *placenta percreta* in the uterus of the plaintiffs, or to foresee the events that happened. Thus, it is impossible to suggest that the first defendant should proceed with CS when there is a complaint of pain due to *placenta percreta*. This suggestion may only hold good, upon hindsight. There is no doubt that if *placenta percreta*, was detected, CS could probably prevent the first plaintiff's collapse as well as the eventual condition befallen on the second plaintiff.

[144] In the final analysis there was no evidence to suggest that it was *uterine rupture* that caused the bleeding. Evidence is clear that the rupture of the uterine vein at the outer wall of the uterus led to massive bleeding.

[145] This condition tally with the query in Dr Kuppu Velumani's report when she recorded *possibility of rupture uterus* as her query. This is a sensible record as no one in fact can know for a fact until a surgery had taken place, and upon examination of the uterus that it is found to be a case of *placenta percreta*.

DELAY IN THE MANAGEMENT OF THE FIRST PLAINTIFF

[146] The plaintiffs pleaded case is that, there is delay in the management of the first plaintiff by the first defendant. Such delay in giving attention to the first plaintiff had caused *uterine rupture* and hence the poor result on the birth of the Second plaintiff. The plaintiffs' allegation of delay is based on the following propositions. From the time the plaintiff complained of pain, there was entry by the first defendant to state: *if pain does not subside for LSCS*, with the word *today* cancelled. Dr Kuppu Velumani was alleged to have failed to investigate the cause of pain even though she had earlier made a finding in the earlier CS of the first plaintiff of *uterus-very thin at fundus*. With that finding she should contemplate *uterine rupture*. The first plaintiff having gone through CS before due to CPD and she is left with no choice but to undergo another CS in her second birth. Learned counsel for the plaintiffs contended that because the first defendant did not head to the warning signs, it resulted in the delay of the CS.

[147] The plaintiffs also contended that there was delay in the time taken by the first defendant to bring the plaintiff to the OT. The telephone calls were made by the nurse twice; the first telephone call, at 10.30am and the second telephone call at 10.50am. Dr Kuppu Velumani arrived only at 11am in the ward. Learned counsel also contended that these recorded times were wrong and illogical. He contended that in fact the Dr Kuppu Velumani should instead call on the plaintiff at either 10.30am or 10.45am. On top of that the plaintiffs say Dr Kuppu Velumani states in her report that she saw the plaintiff 45 minutes after the Second CTG which would be 45 minutes after 9.10am.

[148] It would be useful to analyse from records and evidence in relation to time, what could be the possible time Dr Kuppu Velumani came to the ward. As I have earlier stated, from testimonies and records before me, there was nothing to disclose that the first plaintiff was in fact in labour at any time. The decision to do an emergency CS is based on whether the plaintiff would eventually go into labour or not, and hence a wait see position was adopted by the Dr Kuppu Velumani. The need for CS presented itself upon the collapse of the plaintiff in the ward.

[149] The nursing record shows that the plaintiff collapsed at approximately 11.00am. What is more than clear based on the testimonies of the witnesses is that when the patient collapsed, Dr Kuppu Velumani was in the ward and code blue was sounded. From the time of her collapse to the time she arrived at the OT, in all, it took about 15 minutes. Taking into account the resuscitation done, oxygen to be given and the transfer of the first plaintiff to OT it took 15 minutes. Going by the evidence of the expert witnesses, 15 minutes is indeed a reasonable practice of any hospital.

[150] I do not find any evidence to support the suggestion that the first plaintiff in fact collapsed at 10.30am instead, as contended by learned counsel for the plaintiffs. Based on records shown I am more inclined to accept that evidence of the defendants that she collapsed approximately around 11.00am. Thus taking into consideration of the fact that *time* being an approximation, following the logical sequence of event, and the fact that the management of the first plaintiff was indeed in a state of emergency, and the time of collapse was approximately at 11am, the delivery of the second plaintiff within 30 minutes from the time of collapse is acceptable. In fact it is an internationally accepted standard. This fact cannot therefore insinuate delay and poor management on the part of the first defendant given the circumstances.

BURDEN OF PROOF

[151] Mr PS Ranjan in his submissions had on a few occasions raised issues alleging the failure of the defendant to call material witness to either confirm or rebut certain facts. He had submitted that the failure of the defendant to call Dr Azhar to explain and the word *'nitial resuscitation … which I have earlier dismissed*. Legal burden of proof always lies on he who assert. As stated by the Low How Bing J (now JCA) in *Krishnan Nambiar s/o Perabakaran* [2009] 4 MLJ 267 the plaintiff on whom the burden lies has unrestricted access to witness. This is because there is no proprietary right in any particular witness. This means any party is at liberty to compel the attendance of witness by way of subpoena. The often repeated arguments made by the plaintiff on the failure of the defendant to forward witnesses such as Dr Azhar to rebut or affirm that resuscitation did or did not take place in the ward must not be confused with the main principle of a civil litigation that the defendant owe no burden to affirm plaintiff's ascertain. It lies with the plaintiffs, or the person who makes such assertion. Though this case is medical negligent claim, it is no different from any other civil litigation. The legal burden to prove a case always lies with the plaintiff.

[152] It was also suggested in the submission of the plaintiffs that the defendant had failed to plead *time being approximation* I agree with Encik Daryl Goon for the defendant that, there was no necessity for the defendant to do so as there was nothing in statement of claim was pleaded, of the plaintiff that had allowed to on discrepancies in time.

Other issues– difficulties in obtaining records

[153] The plaintiff had also various issues on the conduct of the defendant is reading available records to the plaintiff. The plaintiff contended that the defendant delayed in making availed reasons required for the trial proceeds. In my view the rule of procedure offered enough protection to plaintiff. All the difficulties and allegations by the plaintiff in obtaining documents and reports would be resolved by way of discoveries or the use other civil procedure for further and better particulars. These constraints by the plaintiff, I belief can be addressed through these procedures. It cannot form good reasons with goes to the liability of the defendants.

Allegation of non objectivity of expert witness

[154] Mr PS Ranjan urged this court to view the evidence of Dr Raman as an expert with lesser weight for two main reasons. First, he contended Dr Raman lacks objectivity and was in fact assisting the defendant as a former colleague and friend in his testimony. Secondly the evidence of Dr Raman was recorded by CRT recording and not that of Dr Ong.

[155] In the course of trial Mr PS Ranjan queried why Dr Raman had failed to disclose in his Curriculum Vitae that he co-authored some publications with Dr Kuppu Velumani. To this, Dr Raman explained that his curriculum vitae was sent to the counsel for the defendant via email and was made in two parts in two separate files. The first part was produced in court. the continuation of his curriculum vitae in part ii which contains publications was not appended. he did not realized until it was so pointed out at the trial by the counsel for the plaintiffs. he explained that the failure to send the second part of the curriculum vitae was inadvertent and not with the intention to suppress any information. In cross-examination Dr Raman told the court that Dr Kuppu Velumani was her colleague at University Hospital before and their relationship is casual and professional. It is also true being in the same area of specialisation he co-authored some publications with her. These publications are in fact disclosed in Dr Kuppu Velumani's Curriculum Vitae in exh D40.

[156] He also testified that in the whole Klang Valley there would be around 200 obstetrics and gynaecologists. Dr Raman said he knows most of them including PW3, Dr Ong.

[157] Mr PS Ranjan referred to the case of *Public Prosecutor v Dr Adasen Kangaligam* [1985] 2 MLJ 122 this point. In that case another doctor was charged for voluntarily causing a woman with child to miscarry. Dr Sinnathuray, who was the Dean of the Faculty of Medicine University Malaya at the material time, testified that an abortion performed by the accused was justified. The court having found that such opinion was not supported by reasonable explanation, and having taken into account his demeanour as well as the circumstances of the facts in that which show that he was not free from a motivation of helping a friend out of trouble, rejected his opinion. In the light of that decision learned counsel invited the court to view Dr Raman's testimonies with circumspect. Learned counsel, contended the relationship between Dr Raman and Dr Kuppu Velumani being one time colleagues at University Malaya, and had co-published some articles, raised question on Dr Raman's view given in the present trial.

[158] I have closely examined the facts of the cited case above. In my view the case of *Dr Adasen* is not an authority to suggest that mere colleague or friends will ipso fact disqualify an expert. The case of *Dr Adasen* was decided based on its own facts, the demeanours of the witness, and the opinion given was unsupported by reasonable explanation. It was on that basis that the evidence was rejected.

[159] In the present case it is not established that Dr Raman's evidence is unreliable. He explained why he might have inadvertently missed out sending his publication list to the defendants counsel. He did not dent knowing Dr Kuppu Velumani being in the same medical fraternity. In any event the co-published articles are listed out in Dr Kuppu Velumani's curriculum vitae in exhibit and objections could have been raised. If the intention of the Defendant or Dr Raman was to suppress this information the why disclose it in the cv. Such I cannot infer any deliberate attempt on the part of Dr Raman to suppress information or relationship with the first defendant.

[160] In the circumstances of the present case I am not able to appreciate the objection raised by the plaintiffs. There is no reason to disqualify an expert witness here merely on the basis that they were one time colleagues. Being in the same area of specialisation, it is not uncommon for the doctors or any member of other profession to remain friends with one another. There is no law to suggest that just because the witness is a colleague his opinion is bias.

[161] In accepting or rejecting evidence particularly an opinion of an expert the predominant factor that merits consideration should be based on its scientific value upon critical scrutiny against the whole of other evidence. I have earlier alluded to this point in the earlier paragraphs in deciding to accept the evidence of Dr Raman.

CRT RECORDING

[162] Another issue brought by the plaintiffs' counsel in relation to the testimonies of expert is on the mode of evidence recording. Learned counsel drew the attention of the court that when Dr Ong testified as PW3 his evidence was recorded by the judge manually. Later at the time when Dr Raman testified as DW7 the court was equipped with electronic recording system, the court recording transcription (CRT). Under this system statement made by the witnesses is recorded on real time as he speaks, and the statement would appear on the screen. There is one screen in front of the witness himself, one each in front of counsel for the plaintiffs and defendants and another before the judge. Simultaneously all parties, the witnesses, counsel and the judge are able to see the recorded statement on the respective screens. Sometimes, particularly so on technical medical evidence if the witness who testified finds the testimonies to inaccurately recorded corrections can be made on the spot. Mr PS Ranjan took up issues that the recording done in this way would give advantage to Dr Raman as opposed to the manually recorded testimonies of Dr Ong because he was able to make correction on the screen. This also according to Mr PS Ranjan would give opportunity for witness to think of what is the correct answer to give. He urged this court to give due regards and weight to evidence of these two experts taken into account these two modes of recording.

[163] First it must be appreciated that since this trial went through a long period of time, by the time Dr Raman testified the court employed the electronic recoding system. It is true that the evidence of Dr Ong was recorded manually. It must be emphasised that the mode of recoding differed is not by choice. Draft of manually recorded notes of evidence was sent out to both parties to check and verify the contents before they were finalised. This includes the testimonies of Dr Ong as PW3. I had taken this precaution in view of the fact that some of the testimonies especially that of the medical experts are indeed technically. From records, each party had taken more than one month time to check through the notes of proceedings before they were finalised.

[164] Right at the outset of trial, at the case management stage in pursuant to O 34 of the RHC parties were invited to tender witness statement to expedite trial process. This was not agreed to by learned counsel for the plaintiffs. If witnesses had produced and filed witness statements then at least it will lessen the laborious recording that had to be undertaken. Even though the different modes of recording were employed the plaintiffs had not established grounds as to how they are prejudiced in this whole process to render any part of the testimonies inadmissible. By either methods of recording, I do not see how the plaintiff's are prejudiced because the plaintiff's can raise any objections to any misreporting or inaccurate recording made by the court.

[165] It is rather late in the date for the plaintiff to raise issues on method of recording involving particular by the two expert witnesses. The rule of evidence is set out in the Evidence Act 1950 and the relevant case laws. There is no rule for the court to reject or give weight on based on how they are recorded.

THE APPLICABLE TEST ON MEDICAL NEGLIGENCE

[166] Having analysed the evidence in this case, it is useful to remind ourselves on the applicable test required in a medical negligent suit. Broadly speaking, like all other civil claims the plaintiffs bear the burden of proving negligence on balance of probabilities. Harking back to this principle, to succeed on their claims against the defendants it is incumbent upon the plaintiffs to prove that:

(a) Dr Kuppu Velumani P and Dr Marlik Abu owe the plaintiffs a duty of care and standard of care;

(b) both Dr Velumani and Dr Marlik have breached that duty;

(c) resulting from that breach the plaintiffs suffered damages which are not too remote;

(d) the hospital has breached its duty of care in providing the required services to the plaintiffs; and

(e) vicarious liability would arise if the claim against the first and second defendants succeeds.

[167] Now I will deal with the law on the applicable test to be applied on the negligent against doctors. I am grateful to Low Hop Bing J (now JCA) who has elucidated in so clear fashion, as he is accustomed to do in his many lucid judgment, the development of the applicable test in this area in his decision in *Chien Tham Kong v Excellent Strategy Sdn Bhd & Ors* [2009] 7 MLJ 261; [2008] 1 LNS 411.

[168] The first test known as the *Bolam* test which was enunciated in the case of *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118. The test propounded is that, in a case involving the use of some skill or competence the test of negligence not of an ordinary person but it is the test of the ordinary skilled man exercising and professing to have that skill. Secondly, a doctor is not negligent if he has acted within the practice accepted as proper by a body of his own peers posing similar skill and competence. It does not matter if there is another body with differing opinion that does not accept the action taken by him. Following these tests, the court is constrained from scrutinizing and evaluating the professional conduct of a doctor possessed of a special skill and competence dictates that he is not negligent so long as he has acted in accordance with one of the bodies of opinion and the court cannot declare his action to be negligent. This test gained cognisance in many Malaysian cases of such as *Swamy v Mathews & Anor* [1967] 1 MLJ 142, *Chin Keow v Government of Malaysia and Another* [1967] 2 MLJ 45, *Elizabeth Choo v Government of Malaysia* [1970] 2 MLJ 171. It was accepted by the majority judgment in *Sidaway v Board of Governors of the Bethelm Royal Hospital and Maudsley Hospital and Others* [1985] 1 AC 871.

[169] The dissenting view of Lord Scarman in Sidaway later however was developed in *Rogers v Whitaker* [1992] 17 CLR 479 and in *Bolitho (Administratrix of the estate of Bolitho (deceased) v City and Hackney Health Authority* [1997] All ER 771 Australia. The learned law lords did not apply the *Bolam* test but maintained that the test was still of relevant consideration and proceeded to state the court's view as to whether the doctor in advising his patient gave the consideration which the law requires him to give. This test was applied in *Huck v Cole* [1993] Med LR 393 where the Court of Appeal held that it was appropriate for judges to reject medical expert evidence if the evidence do not stand up to analysis. As quoted in the case of *Chien Tham Kong*, in *Bolitho*, Lord Browne Wilkinson speaking for the House of Lords opines as follows:

(a) the court is not bound to hold that the defendant doctor escapes liability for negligent treatment or diagnosis just because he leads evidence from a number of medical experts who are genuinely of opinion that the defendant's treatment or diagnosis accorded with sound medical practice;

(b) in weighing of risks against benefits the judge before accepting a body of opinion as being responsible or respectable will need to be satisfied that in forming their views the experts have directed their minds to the question of comparative risks and benefits and have reached a defensible conclusion on the matter;

(c) in case of diagnosis and treatment there are cases where despite a body of professional opinion sanctioning the defendant's conduct the defendant can properly be held liable for negligence because in some cases it cannot be demonstrated to the judge's satisfaction that the body of opinion relied on is reasonable or responsible; and

(d) If in a rare case it can be demonstrated that the professional opinion is not capable of withstanding logical analysis, the judge is entitled to hold that the body of opinion is not reasonable or responsible.

[170] In the Australian case of *Rogers v Whitaker* (1992) 175 CLR 479 the Supreme Court of New South Wales, the Court of Appeal of ultimately the High Court of Australia declared that the standard of care is not determined solely by reference to the practice followed by one responsible body of opinion in the profession. The court have adopted the principle that while evidence of expert medical practitioners is a useful guide it is for the court to adjudicate on what is the appropriate standard of care after giving weight to consideration that a person is entitled to make his own decision about his life. This came to be known as the *Rogers* test which in fact gained recognition in the Federal Court decision in *Foo Fio Na v Dr Fook Mun & Anor* [2007] 1 MLJ 593; [2007] CLJ 229. This test requires the medical profession to stand up to the wrong doings; this court and not the medical profession must decide on the liability of doctors in defending medical negligence cases. Thus, the court may accept or reject the medical expert evidence, which do not stand to up to a logical analysis. In doing so in the context of the position in Malaysia, due regards be had to s 45 of the Evidence Act 1950. Under this section, due regards must be given to relevancy of the opinion of the expert and when the court has to form opinion upon a particular point the opinion of the medical expert specially skilled in that field are relevant facts.

[171] Another factor that always need to borne in mind is what has been stated by Lord Scarman in *Maynard v West Midlands* [1985] All ER 635*that it is not enough to show that subsequent events show that the operation need never have been performed, if at that time the decision to operate was taken it was reasonable in the sense that a responsible body of medical opinion would have accepted it as proper*.

[172] Guided by the above principles I will conclude as follows. No doubt both the defendants Dr Kuppu Velumani and Dr Marlik Abu owe the plaintiffs a duty and standard of care. However the plaintiffs have failed to proof on balance of probabilities that they were in breach of such duties of care, when the plaintiffs failed to show on evidence that the first plaintiff was in labour to merit an earlier CS to be performed on her.

[173] The plaintiffs failed to proof that there was *uterine rupture* which is foreseeable and preventable by the first defendant in view of the first plaintiff's history in her first pregnancy. On the other hand sufficient evidence was established to show that the first plaintiff was suffering from an abnormal presentation of the uterus which is the rarest kind known as *placenta percreta*. Such abnormal presentation is rare and cannot be detected by any sophisticated machine except by way of surgery. Consequently the vicariously liability on the sixth defendant does not arise, as no liability had been attributed to Dr Kuppu Velumani and Dr Marlik Abu.

[174] Finally, it has to be appreciated and empathised that these two plaintiffs, both the mother and the baby and I am sure the whole family have suffered such terrible consequences from this episode. I do sympathise with the predicament of the plaintiffs. It is only normal and natural that looking at their sufferings there is feeling of sympathy and the only available remedy is to compensate them. However, it is equally important for the larger benefit of the society that hospitals and doctors must not be led to provide us their medical services by thinking more of their own safety than of the goods of their own patients. It will be a disservice to the community at large to impose liability on hospitals and doctors for everything that happens to go wrong. A proper sense of proportion requires us to have regards to the conditions in which hospitals and doctors have to work. We must insist on due care for the patient at every point, but we must not condemn as negligence that which is only a misadventure.

[175] Thus, based on the above I hold that the plaintiffs have failed to establish their claim against the defendants I am constrained to determine their claim by the entire evidence. It is with regrets that I am dismissing the plaintiffs' claim with costs.

Appeal dismissed with costs.

Reported by Afiq Mohamad Noor